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Supreme Court, U.S.
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In The
Supreme Court of the United States

CONSTRUCTION LABORERS PENSION TRUST FOR SOUTHERN CALIFORNIA,

Petitioner,

v.

EIJINIO BANUELOS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

JOHN S. MILLER, JR.*
CHARLES E. NONEMAN
COX, CASTLE & NICHOLSON LLP
2049 Century Park East,
28th Floor
Los Angeles, CA 90067-3284
Telephone: (310) 277-4222
Facsimile: (310) 277-7889

Counsel for Petitioner,
Construction Laborers Pension Trust For Southern California

**Counsel of Record*

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COCKLE LAW BRIEF PRINTING CO (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

Denial of a motion for summary judgment pursuant to FRCP 56 is not traditionally appealable after a trial on the merits. Issues of law raised therein may be preserved pursuant to 28 U.S.C. section 1292(b), trial objections, and motions pursuant to FRCP 50 and 59. Respondent/plaintiff below, following trial, prosecuted an appeal only from an earlier denial of a motion for summary judgment. The Court of Appeals granted plaintiff's appeal, holding that the district court's denial of plaintiff's evidentiary objection in the hearing on the motion for summary judgment was an "issue of law" appealable even after trial.

The first question presented is:

1. Whether a district court's denial of a party's motion for summary judgment after a plenary trial on the merits is appealable or whether the disappointed litigant is required to preserve the issues raised in the motion for summary judgment by interlocutory appeal or by appropriate motions during and following trial.

ERISA and the interpretive regulations of the U.S. Department of Labor require pension and other employee benefit plans to maintain an administrative claims review process that is efficient, cost-effective and flexible and that provides a full and fair review of the benefit claims of participants. ERISA empowers the courts to review the decisions of trustees and to award participants benefits payable under the terms of employee benefit plans and other equitable relief but not monetary damages or other economic sanctions. The Court of Appeals relied upon evidence of respondent/plaintiff never introduced into petitioner/defendant Trust's administrative record as to the alleged terms of

QUESTIONS PRESENTED – Continued

the Trust's Pension Plan, excluded rebuttal evidence of the Trust as to the terms of its Pension Plan because such evidence was not in the administrative record, and awarded respondent/plaintiff a type of pension benefit never promised or adopted by the Trust in its Pension Plan.

The remaining questions presented are:

2. Whether the courts have warrant under ERISA to impose on the plan administrators of employee benefit plans, such as the Trustees of the Trust, discrete burdens to anticipate all arguments a participant may later make in court as to the content, history, adoption, validity, interpretation and application of a plan administrator's benefit plan and to introduce into the administrative record of its own proceeding before deciding the participant's benefit claims all documents and testimony under oath necessary to rebut all such arguments and to support the administrator's determination of the participant's claim.

3. Whether courts under ERISA (a) may decline to remand to a plan administrator for initial consideration evidence that was not previously introduced into the administrative record for the benefit claim but that concerns proof of the actual terms and conditions of the benefit plan maintained by the plan administrator, (b) refuse, alternatively, to permit judicial consideration of such evidence on the ground that it was not in the administrative record and (c) have jurisdiction on a record rendered incomplete by virtue of the excluded evidence to award monetary damages against the plan in the form of a type of benefit never promised by or adopted by the plan administrator.

PARTIES TO THE PROCEEDING

Petitioner is the Construction Laborers Pension Trust for Southern California.

Respondent is an individual, Eijinio Banuelos.

RULE 29.1 LISTING

The Construction Laborers Pension Trust for Southern California has no parent ownership, and no subsidiaries (other than wholly-owned subsidiaries).

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OPINIONS BELOW

The opinion of the Court of Appeals is reported at 382 F.3d 897 (9th Cir. 2004). *See* Appendix ("App.") at 1-12. The order denying the petition for rehearing and suggestion for rehearing *en banc* is unreported. *See* App. at 50. The findings of fact and conclusions of law following trial by the United States District Court for the Central District of California are unreported. *See* App. at 14-30.

JURISDICTION

The judgment of the Court of Appeals was filed and entered on August 24, 2004. *See* App. at 13. A petition for rehearing and suggestion for rehearing *en banc* was denied by order filed on December 8, 2004. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

RELEVANT STATUTES AND REGULATIONS

The primary statutes and regulations involved are Federal Rules of Civil Procedure 50, 56 and 59, 28 U.S.C. section 1292(b), section 502(a)(1)(B) and section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a)(1)(B) and 1133, and Title 29 Code of Federal Regulations Part 2560, Section 2560.503. *See* App. at 51-77.

STATEMENT

Procedural Background

On May 24, 2000, respondent Eijinio Banuelos ("Banuelos") filed this action in the United States District Court for the Central District of California against the petitioner Construction Laborers Pension Trust for Southern California (the "Trust") seeking to recover pension benefits from the Trust.

By amended order filed September 24, 2001, the district court denied the parties' cross-motions for summary judgment. *See* App. at 31-49.

On August 20 and 21, 2002, a two-day trial was held before the district court. On November 8, 2002, the district court filed its "Findings of Fact and Conclusions of Law; Order Thereon," finding in favor of the Trust and against Banuelos. Banuelos filed his Notice of Appeal in the Ninth Circuit on December 3, 2002. While Banuelos purported to appeal both from the district court's Findings of Fact and Conclusions of Law and from the order denying his motion for summary judgment, Banuelos subsequently limited his appeal to the district court's ruling denying his motion for summary judgment.[1]

Statement of Facts

Eijinio Banuelos worked as a construction laborer in Southern California from 1966 through 1991. His employment resulted in his being a participant in petitioner/defendant Construction Laborers Pension Trust for Southern California. The Trust is a multiemployer plan with over 20,000 participants and beneficiaries. Since 1962, the

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[1] Banuelos has made it clear that he was not appealing the district court's Findings of Fact and Conclusions of Law following the trial, and was only appealing the district court's ruling on his motion for summary judgment. Banuelos declined to order and include in the record on appeal the transcript of the trial proceedings, or any of the exhibits introduced into evidence at trial. See Plaintiff's Transcript Designation and Ordering Form filed on or about February 10, 2003 (stating "I do not intend to order any part of the transcript"). The Trust then designated the trial transcript as part of the record pursuant to Circuit Court Rule 10-3.1(b). Banuelos then certified that the transcript of the trial was unnecessary because "Plaintiff's appeal herein is solely based upon the [district] court's denial of his summary judgment motion," pursuant to Circuit Court Rule 10-3.1(f). Banuelos further acknowledged that if the district court did not commit legal error in denying his motion for summary judgment, "plaintiff cannot win an appeal in the absence of the reporter's transcript." See Certification filed March 3, 2003 in the district court. The Trust filed a motion to compel Banuelos to pay for the transcript pursuant to Circuit Court Rule 10-3.1(f). In his opposition filed with the district court on or about March 7, 2003, Banuelos stated "plaintiff has elected to appeal only the court's amended order . . . denying plaintiff's motion for summary judgment.

Trust has been established and maintained under collective bargaining agreements between the Southern California District Council of Laborers and its affiliated local unions (the "District Council"), representing its members including Banuelos, and several multiemployer trade associations, representing more than a thousand contributing employers to the Trust.

Banuelos applied for a pension from the Trust in August 1999. In connection with his application, he never asked the Trust for a copy of the Pension Plan or other information. The Trust denied Banuelos' application for a pension, advising that he was currently ineligible but could become eligible with limited further service. Banuelos appealed the denial.

Banuelos submitted a letter of appeal through his attorney, Mr. Richard Weinstock ("Weinstock"). Weinstock submitted a letter to the Trust quoting a purported section of the Pension Plan of the Trust, Section 4.07(e). Weinstock did not submit any plan provisions with his letter. The Trust denied Banuelos' appeal.

The language quoted by Weinstock in his letter was not the language of Section 4.07(e) of the Pension Plan of the Trust. The language quoted by Weinstock purported to grant vesting after five years of service to participants in the Trust after 1988. If true, it would have rendered Banuelos eligible for a pension. But the Pension Plan was amended effective January 1, 1989 to provide five-year vesting only to certain participants not covered by a collective bargaining agreement. (This coverage was required to be given to such participants by the Tax Reform Act of 1986.) Banuelos' employment was covered by a collective bargaining agreement. Thus, he remained subject to the traditional ten-year vesting of the Pension Plan of the Trust. (Five-year vesting was eventually adopted – at a cost of approximately $50,000,000 – for participants whose employment was covered by a collective bargaining agreement and who worked one or more hours after 1998.)

Banuelos filed suit. He attached as Exhibit 1 to his complaint a purported copy of the Pension Plan of the Trust. This copy was referenced by the Court of Appeals as the "1994 Plan."

As proved at trial, Exhibit 1 was not the 1994 Pension Plan of the Trust. It was never a Pension Plan of the Trust. The Trustees of the Trust had never even seen the document before its attachment to the complaint. It was, instead, a working document of the Trust's lawyers. It attempted to track the effect of plan amendments on the text of the Pension Plan of the Trust. This working document text was filled with underscored additions, bracketed deletions, and a plethora of footnotes indicating which plan amendment caused which addition or deletion in text.

The attachment of this work product of the Trust's counsel as Exhibit 1 to the complaint revealed it to be the source of the supposed Section 4.07(e) quoted in Weinstock's appeal letter to the Trust. But the appearance of this language in the lawyers' working document that was attached as Exhibit 1 was incorrect. It was language that had been proposed as part of an amendment to the Pension Plan of the Trust by one of the Trust's lawyers but that had been rejected by the Trustees of the Trust at its initial reading. The language quoted by Weinstock was, instead, deleted from the amendment at its second reading and a new definition of Normal Retirement Age – as required by the Omnibus Budget Reconciliation Act of 1989 – was officially adopted at that time. (The correct text as officially adopted at the second reading also appeared in Exhibit 1 to the complaint.)

This working document of the Trust's attorneys was never a part of the administrative record of Banuelos' application for pension benefits or of his appeal to the Trust. No copy of it was ever provided to the Trust by Banuelos or by his attorney in connection with Banuelos' application for pension benefits and appeal.

Banuelos' counsel for his appeal, Weinstock, instead advised the district court in his motion for summary judgment that he had come into possession of the lawyers'

working document that he attached as Exhibit 1 to the complaint not in connection with his representation of Banuelos but in his representation of a different plan participant in an earlier, unrelated matter.

In the other matter not involving Banuelos, Weinstock had requested from the Trust a copy of the Pension Plan and related documents. An employee of the Trust's third party administrator mailed to Weinstock the Trust's summary plan description which included the full text of the Pension Plan as of the date of publication of the summary plan description together with copies of the amendments to the plan since publication of the summary plan description. The employee also included with these materials a copy of the lawyers' working document. The latter document was unknown to the Trustees and the transmission was unknown to the Trust's attorneys who were unaware that the employee even had a copy of the working document.

Answering Banuelos' complaint, the Trust denied that Exhibit 1 was the Pension Plan of the Trust. The parties filed cross-motions for summary judgment.

Banuelos objected to the Trust's evidence that Exhibit 1 was not the Pension Plan of the Trust, because the Trust's evidence was not in the administrative record before the Trust. Banuelos conveniently ignored the fact that neither Exhibit 1 nor his explanation of how he came by it was in the administrative record either. The Trust objected to Banuelos' evidence outside the administrative record, including Exhibit 1.

In response to Banuelos' objection, the Pension Trust moved to remand the matter to the Appeals Committee of the Trust so that the appropriate Trustees of the Trust could address in the first instance Banuelos' contention that Exhibit 1 was the Pension Plan of the Trust.

The district court denied the Trust's motion, ruled that the court had jurisdiction to determine the "threshold question" of what were the terms of the Trust's Pension Plan, and denied the cross-motions for summary judgment

to address triable issues of fact at trial as to whether Exhibit 1 was the Pension Plan of the Trust.

Banuelos did not request an interlocutory appeal of the denial of his motion for summary judgment.

The district court thereafter conducted a two-day bench trial. The district court admitted Banuelos' evidence of Exhibit 1 and the circumstances of Weinstock's acquisition of it. The district court admitted evidence of the Trust's Pension Plan, the amendments thereto and the facts and circumstances related to the actual content of the Trust's Pension Plan and the creation and content of the lawyers' working document, Exhibit 1 to the complaint. The district court ruled after trial that Exhibit 1 was not the Pension Plan of the Trust, that the language of Section 4.07(e) quoted by Weinstock in Banuelos' appeal letter was not language in the Pension Plan of the Trust and that, in the alternative, if Exhibit 1 was to be treated as the Pension Plan of the Trust, then it had to be reformed to correct a scrivener's error.

Banuelos did not protect his right to appeal from the district court's rejection of his objections to the evidence proffered by the Trust, which evidence was not proffered to the Trust's Appeals Committee. Banuelos made no motions before, during or after the trial to protect his right to challenge the district court's admission of evidence during the trial. Banuelos initially appealed both from the judgment at trial and from the district court's earlier denial of his motion for summary judgment, asserting that the district court should have granted his motion because the Trust's evidence that Exhibit 1 was not the Pension Plan of the Trust had never been placed by the Trust's Appeals Committee into its own "administrative record." Shortly thereafter, Banuelos abandoned his appeal from the judgment after trial and pursued exclusively his appeal from the earlier denial of his motion for summary judgment.

The Trust objected to the appeal on the grounds that a denial of a motion for summary judgment is not appealable after a trial on the merits, that the Trust was entitled

to submit evidence to the district court at trial because Exhibit 1 itself was never a part of the administrative record, that the issue of the actual terms of the Pension Plan of the Trust was a threshold issue permissibly determined by the district court, that the Trust had requested remand to the Appeals Committee in response to Plaintiff's original objection to the evidence, that the Trust had proven at trial that Exhibit 1 was not the Pension Plan of the Trust, that a Pension Plan cannot be estopped into paying benefits not provided under the terms of the Plan, and that, in any event, Banuelos could not meet the elements of estoppel. The Trust requested the appeal be denied.

The Court of Appeals determined that it could review the district court's denial of Banuelos' motion for summary judgment and then ignored the issue whether Banuelos' Exhibit 1 was part of the administrative record. It issued a decision premised upon the facts and circumstances offered by Banuelos in his own motion for summary judgment, evidence that was itself outside the administrative record, including Exhibit 1, and how counsel for Banuelos acquired Exhibit 1 in the different matter unrelated to Banuelos. The Court of Appeals concluded that the conflicts between the never-adopted, unauthorized Exhibit 1 and the actual Pension Plan of the Trust could be resolved judicially in the same manner as conflicts between an actual pension plan of a trust and an authorized summary plan description of that same trust, with the participant receiving the more favorable interpretation of the two documents.

The Trust petitioned for rehearing and rehearing *en banc*. The Trust asserted as grounds (1) that the Court erred in preventing the Trust from offering evidence beyond that of the administrative record to establish the true terms of the Pension Plan and in order to address Banuelos' evidence that was itself not part of the administrative record, and (2) that any relief should come in the form of a remand since damages should not be awardable to a participant in the form of benefits never adopted as part of a pension plan of an ERISA-regulated trust.

The Trust's petition was denied. This petition follows.

REASONS FOR GRANTING THE WRIT

I.

The Decision Of The Ninth Circuit To Review On Appeal The Denial Of A Motion For Summary Judgment After A Full Trial On The Merits Eviscerates The Procedural Constraints On Appeals Of Interlocutory Motions Under 28 U.S.C. Section 1292(b), Pointlessly Augments Existing Procedural Avenues Of Trial Objections And Motions During And After Trial By Which Litigants May Preserve Legal Issues For Appeal, Deprives District Courts Of Their Discretion To Deny Motions For Summary Judgment In Preference For Trial, Creates Entirely New Avenues For And Categories Of Appeal Of Issues Requiring Consideration Of Two Different Evidentiary Records, And Conflicts With The Decisions Of All Other Circuits Save The Seventh Circuit Which Has Begun To Follow This Newly-Adopted Exception.

The Ninth Circuit's decision below builds upon its earlier decision in *Pavon v. Swift Transportation Co., Inc.*, 192 F.3d 902 (9th Cir. 1999), which first created an "issue of law" exception to the rule against the appealability of the denial of a motion for summary judgment. Recently, the Seventh Circuit decided to follow the Ninth Circuit's creation of this "issue of law" exception to the general rule that summary judgment denials may not be reviewed following trial on the merits. *See Chemetall GMBH v. ZR Energy, Inc.*, 320 F.3d 714 (7th Cir. 2003). While the Fourth and Eighth Circuits have criticized the logic of the Ninth Circuit's "issue of law" exception,[2] the opinion below demonstrates that the Ninth Circuit and the Seventh Circuit will continue to use this "issue of law" rationale to enlarge the exception to the general rule that summary judgment denials are non-reviewable after trial.

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[2] *See*, Section I, B, *infra*.

A. Circuit Courts Have Universally Followed The Rule Foreclosing The Court Of Appeals From Revisiting A District Court's Ruling Denying Summary Judgment After A Full Trial On The Merits.

Until the Ninth Circuit embarked upon its new course, virtually every Circuit Court embraced the general rule that a Court of Appeals will not review the denial of summary judgment by the district court following a full trial on the merits. *See Lama v. Borras*, 16 F.3d 473, 476 n.5 (1st Cir. 1994); *Pahuta v. Massey-Ferguson, Inc.*, 170 F.3d 125, 130 (2d Cir. 1999); *Chesapeake Paper Products Co. v. Stone & Webster Engineering Corp.*, 51 F.3d 1229, 1237 (4th Cir. 1995); *Black v. J.I. Case Co. Inc.*, 22 F.3d 568, 569-570 (5th Cir.), *cert. denied*, 513 U.S. 1017, 115 S.Ct. 579, 130 L.Ed.2d 494 (1994); *Jarrett v. Epperly*, 896 F.2d 1013, 1016 (6th Cir. 1990) *rehearing denied* (1990); *Watson v. Amedco Steel, Inc.*, 29 F.3d 274, 278 (7th Cir. 1994); *Metropolitan Life Insurance Co. v. Golden Triangle*, 121 F.3d 351, 354 (8th Cir. 1997); *Locricchio v. Legal Services Corp.*, 833 F.2d 1352, 1359 (9th Cir. 1987); *Whalen v. Unit Rig, Inc.*, 974 F.2d 1248, 1250-1251 (10th Cir. 1992), *cert. denied*, 507 U.S. 973, 113 S.Ct. 1417, 122 L.Ed.2d 787 (1993); *Lind v. United Parcel Service, Inc.*, 254 F.3d 1281 (11th Cir. 2001); *Glaros v. H.H. Robertson Co.*, 797 F.2d 1564 1573 (Fed. Cir. 1986), *cert. dismissed*, 479 U.S. 1072, 107 S.Ct. 1262, 94 L.Ed.2d 124 (1987); *Cf. Hopp v. City of Pittsburgh*, 194 F.3d 434, 439 n.3 (3d Cir. 1999) (court rejected City's challenge to district court's denial of motion for summary judgment, stating "since the case proceeded to trial . . . our review is limited to the . . . denial of the City's Rule 50 motion").

Many reasons have been expressed in support of the rule.

In *Lama v. Borras*, 16 F.3d 473, 476 n.5 (1st Cir. 1994), the First Circuit declined to entertain an attack on the district court's denial of a party's motion for summary judgment because the denial "has been overtaken by subsequent events, namely, a full-dress trial and an adverse jury verdict."

The Fifth Circuit has held that it lacks *jurisdiction* to consider a denial of summary judgment following a full trial on the merits. *Brown v. Slenker*, 220 F.3d 411, 421 n.9 (5th Cir. 2000).[3] The Fifth Circuit relied on its earlier opinion in *Wells v. Hico Independent School District*, 736 F.2d 243, 261 n.9 (5th Cir. 1984), *cert. dismissed*, 473 U.S. 901, 106 S.Ct. 11, 87 L.Ed.2d 672 (1985), in which the court noted: "Once trial began, the summary judgment motions became moot." In *Black v. J.I. Case Co. Inc.*, 22 F.3d 568, 572 (5th Cir. 1994), *cert. denied*, 513 U.S. 1017, 115 S.Ct. 579, 130 L.Ed.2d 494 (1994), the court reasoned:

> [P]rudential concerns argue against reviewing such motions. To review the pretrial denial of a motion for summary judgment, we would have to review two different sets of evidence: the "evidence" before the district court at pretrial when it denied the motion, and the evidence presented at trial. Of course, the "evidence" presented at pretrial may well be different from the evidence presented at trial.

In embracing the general rule, the Eleventh Circuit noted that "[s]ummary judgment was not intended to be a bomb planted within the litigation at its early stages and exploded on appeal." *Holley v. Northrop Worldwide Aircraft Services, Inc.*, 835 F.2d 1375, 1377-78 (11th Cir. 1988).[4]

In a case often cited by other Circuits, the Ninth Circuit observed:

> To be sure, the party moving for summary judgment suffers an injustice if his motion is improperly denied. This is true even if the jury decides in his favor. The injustice arguably is greater when the verdict goes against him. However, we believe it would be even more unjust to

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[3] The Ninth Circuit has also framed the issue as one of jurisdiction. *Dowling v. Davis*, 19 F.3d 445, 446 n.2 (9th Cir. 1994).

[4] Of course, this is precisely the effect of the decision below in this case.

> deprive a party of a jury verdict after the evidence was fully presented, on the basis of an appellate court's review of whether the pleadings and affidavits at the time of the summary judgment motion demonstrated the need for a trial.

Locricchio v. Legal Services Corp., 833 F.2d 1352, 1359 (9th Cir. 1987).

In sum, virtually all Circuit Courts have followed the general rule that it is an idle act for a Court of Appeals to review the denial of a motion for summary judgment following a full trial on the merits. *See also Black v. J.I. Case Co., Inc.*, 22 F.3d 568, 570-72 (5th Cir. 1994) (containing a comprehensive discussion of the rule and the reasons supporting the rule); W. Moore, Moore's Federal Practice § 56.41[3][d] (3d Ed. 2004).

B. The Ninth Circuit's Decision Expressly Conflicts With The Decisions Of All Other Circuit Courts, Except The Seventh Circuit Which Has Begun To Follow The Ninth Circuit's Lead.

The Ninth Circuit recently created a brand new exception to the general rule. In *Pavon v. Swift Transportation Co. Inc.*, 192 F.3d 902 (9th Cir. 1999), the Ninth Circuit held that since "claim preclusion" was an "issue of law" which involved no factual issues to be submitted to the trier of fact, the court would consider a district court's denial of a party's motion for summary judgment even after a full trial on the merits.

In deciding to review the district court's denial of Banuelos' motion for summary judgment, the Ninth Circuit expanded on *Pavon's* "issue of law" exception, holding that it was an error of law for the district court to consider evidence outside the administrative record (i.e., the Trust's mistake evidence) to find a triable issue of fact.[5]

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[5] The Ninth Circuit conveniently ignored the Trust's objection that Banuelos' evidence in the form of Exhibit 1 to the Complaint and the

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382 F.2d 902-03. The Seventh Circuit has also begun to follow the "issue of law" exception announced in *Pavon*. *See Chemetall GMBH v. ZR Energy, Inc.*, 320 F.3d 714 (7th Cir. 2003).

Two other Circuit Courts have squarely rejected the "issue of law" exception. In *Metropolitan Life Insurance Co. v. Golden Triangle*, 121 F.3d 351 (8th Cir. 1997), the Eighth Circuit rejected it as unworkable:

> We further conclude that Met Life's proposed dichotomy, between a summary judgment denied on factual grounds and one denied on legal grounds, is both problematic and without merit. Since we do not require a district court to delineate why it denied summary judgment, were we to accept Met Life's proposed distinction, we would be required "to engage in the dubious undertaking of determining the bases on which summary judgment is denied and whether those bases are 'legal' or 'factual.'" Thus Met Life asks us to adopt an "approach [that] would require us to craft a new jurisprudence based on a series of dubious distinctions between law and fact," inviting potentially confusing and inconsistent case law to benefit only those summary judgment movants who have failed to abide by the Federal Rules of Civil Procedure. We find such an approach to be unjustified and decline to adopt it.

Id. at 355 (citations and footnotes omitted). Noting that its decision was in harmony with the majority of other courts, the Eighth Circuit emphasized that a departure from the general rule prohibiting a review of a denied motion for summary judgment was unnecessary since litigants have existing, well-defined avenues for preserving appeals on "issues of law." To adopt the Ninth Circuit exception, the Eighth Circuit reasoned, would condone a litigation strategy that disregards Federal Rules of Civil Procedure

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story of his counsel's earlier acquisition of Exhibit 1 was also outside the administrative record.

50(a) and 50(b)[6] and 28 U.S.C. section 1292(b), and that would undermine the discretion of a district court to "deny summary judgment in a case where there is reason to believe that the better course would be to proceed to a full trial," *citing Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513, 91 L.Ed.2d 202 (1986).

The Fourth Circuit has also rejected the "issue of law" exception. *Chesapeake Paper Products Co. v. Stone & Webster Engineering Corp.*, 51 F.3d 1229, 1235 (4th Cir. 1995). In reasoning similar to that of the Eighth Circuit, the court stated:

> We reject the contention that our review should depend on whether the party claims an error of law or an error of fact. Such a dichotomy is problematic because all summary judgment decisions are legal decisions in that they do not rest on disputed facts. The legal nature of summary judgment decisions is evident from our traditional *de novo* standard for reviewing such decisions. Furthermore, such a dichotomy would require this Court to engage in the dubious undertaking of determining the bases on which summary judgment is denied and whether those bases are "legal" or "factual." The Federal Rules of Civil Procedure do not require such a dichotomy in summary judgment denials, *see* Fed.R.Civ.P. 56(c), and we decline to create a new jurisprudence in which district courts would be obliged to anticipate parties' arguments on appeal by bifurcating the legal standards and factual conclusions supporting their decisions denying summary judgment . . . .

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[6] MetLife failed to file a motion for judgment as a matter of law at the close of evidence, and it failed either to renew its motion for judgment as a matter of law, or to file a motion for a new trial within ten days after the trial court entered judgment. *See* Fed.R.Civ.P. 50(a), 50(b), 59(b).

> Most importantly, bifurcating summary judgment decisions based on law and fact is unnecessary because a party that believes the district court committed legal or factual error in denying summary judgment has adequate remedies other than seeking review of the denial after a full trial. First, a party may move for judgment as a matter of law under Fed.R.Civ.P. 50 and then seek appellate review of the motions if they are denied . . . .
>
> Second, a party that believes the district court committed error in denying summary judgment may move the court to certify the denial for interlocutory appeal pursuant to 28 U.S.C. § 1292(b).

Id. at 1235, 1236-37 (citations omitted).

The First Circuit would also have reached a different result in this case. In *Rivera-Torres v. Ortiz Velez*, 341 F.3d 86, 92 (1st Cir. 2003), *cert. denied*, ___ U.S. ___, 124 S.Ct. 1875, 158 L.Ed.2d 466 (2004), the court refused to entertain the argument that evidence should not have been considered by the district court at the summary judgment stage because it was inadmissible, relying on the general rule that, because the appeal followed a full trial on the merits, the district court's ruling was "overtaken by subsequent events."

No good reason exists for the Ninth Circuit's "issue of law" exception. It is simply unnecessary. A party whose motion for summary judgment is denied does not lose his right to challenge any substantive legal issues embedded in the motion. First, the party may always seek to appeal the interlocutory order under 28 U.S.C. section 1292(b). Second, where a jury trial has occurred, the party may move for judgment as a matter of law under Federal Rule of Civil Procedure 50 and seek appellate review of the motion if it is denied. *Eaddy v. Yancey*, 317 F.3d 914, 916 (8th Cir. 2003); *Lind v. United Parcel Service*, 254 F.3d 1281, 1285 (11th Cir. 2001). Finally, in a non-jury trial, the party may preserve all legal issues arising at the summary

judgment stage (e.g., objections to evidence) by making an appropriate record during trial.

It is clear that this case would have been decided differently by the First Circuit, the Fourth Circuit and the Eighth Circuit. The three courts would each have rejected the invitation to revisit the district court's denial of Banuelos' motion for summary judgment based on the distinction that it involved an issue of law. This conflict among the Circuits ought to be resolved, and a uniform rule ought to govern the Circuit Courts.

C. The Ninth Circuit Rule Prohibits A District Court From Exercising Long-Recognized Discretion.

This Court has held that a district court judge may deny a motion for summary judgment in a case where there is reason to believe that the better course would be to proceed to a full trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513, 91 L.Ed.2d 2505 (1986).

Citing this language, many Courts of Appeals have held that the district courts have *discretion* to deny a party's motion for summary judgment if a district court has any doubt about the propriety of granting the motion. *See, e.g., Metropolitan Life Insurance Co. v. Golden Triangle*, 121 F.3d 351, 355 (8th Cir. 1997); *Veillon v. Exploration Services, Inc.*, 876 F.2d 1197, 1200 (5th Cir. 1989).

This principal has also been recognized in the leading treatises on federal civil procedure. *See* 10 C. Wright, A. Miller, M. Kane, Federal Practice & Procedure, Civil § 2728 (3d Ed. 1998); W. Moore, Moore's Federal Practice § 56.41[3][d] (3d Ed. 2004).

The Ninth Circuit rule undermines the discretion of the trial judge to send a case to trial, which conflicts with *Anderson v. Liberty Lobby, Inc.*, and the precedents of other Circuit Courts.

D. The Ninth Circuit's Rule Will Provide Losing Parties With An Additional And Pointless Avenue Of Appeal, Increasing The Workload Of The Circuit Courts.

The issue of allowing the Court of Appeals to re-examine a district court's denial of a party's motion for summary judgment after a full trial on the merits is one of substantial significance to the administration of federal courts.

While petitioner has not been able to find any statistics or studies which directly address the issue, there is little doubt that, in the percentage of cases that have actually proceeded through trial in district court, one or the other of the parties will have filed a motion for summary judgment in a very high percentage of those cases, which has been denied (at least in part) by the trial judge. In each case where a party filed such a motion, and then lost at trial, the Ninth Circuit's opinion opens a completely new avenue for appeal. The losing party at trial merely needs to assert that the trial court committed an error of law in ruling on the party's motion for summary judgment, and the Circuit Court must now address issues of law as they arise from *two* sets of evidence on appeal – the one before the district court at the summary judgment stage, and the one before the trial court during the trial stage. *General Signal Corp. v. MCI Telecommunications Corp.*, 66 F.3d 1500, 1507 (9th Cir. 1995); *Black v. J.I. Case Co., Inc.*, 22 F.3d 568, 572 (5th Cir. 1994), *cert. denied,* 513 U.S. 1017, 115 S.Ct. 579, 130 L.Ed.2d 494 (1994). In many cases, this will double the work before the appellate court in the particular appeal, imposing additional strains on judges and their staff, which are already overburdened by an ever-increasing number of appeals.[7] In other cases,

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[7] The Federal Reporter system contains a number of cases in which the Courts of Appeals have wasted energy reviewing the denial of a motion for summary judgment after a full trial on the merits without any consideration of whether they were authorized to do so. *See, e.g., Wilson Arlington Co. v. Prudential Insurance Co.*, 912 F.2d 366 (9th Cir.

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where a party failed to preserve issues of law at trial, new appeals are available, unnecessarily benefiting a party that neglected its record at trial, and adversely burdening the other litigants with a need to defend an issue not on the full record and development of the case, but on a lesser record from a preliminary stage of the case. Finally, new appeals will arise where counsel omit to re-address legal issues during trial, thereby depriving district courts of the opportunity to correct their own errors (or, through their ruling to persuade counsel they are correct) by reconsidering their earlier decisions on a more thoroughly-developed presentation of the case.

II.

The Ninth Circuit's Decision Barring The District Court From Considering Evidence Outside The Administrative Record, Declining To Remand The Evidence Issues Back To The Trust As Plan Administrator, And Awarding Banuelos Pension Benefits Of A Type Never Promised By Or Adopted By The Trust Impermissibly Conflicts With Section 503 Of ERISA, With The Department Of Labor's Claims Processing Regulations, With The Decisions Of This Court And Of Other Circuit Courts Of Appeals, And Constitutes An Improper Award Of Damages In Excess Of The Court's Jurisdiction Under Section 502 Of ERISA.

The decision below merits the urgent review of this Court. It imposes tremendous new burdens on ERISA plan administrators to create an exhaustive administrative record of plan documents and testimony in every benefit claim proceeding. Failure to do so leaves a plan

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1990), cited by the Ninth Circuit in *Banuelos; Savarin Corp. v. National Bank of Pakistan*, 447 F.2d 727, 728, 732 (2d Cir. 1971). See also the cases cited in *Chesapeake Paper Products Co. v. Stone & Webster Engineering Corp.*, 51 F.3d 1229, 1234 and 1235 n.7 (4th Cir. 1995), and *Metropolitan Life Insurance Co. v. Golden Triangle*, 121 F.3d 351, 354-55 (8th Cir. 1997).

administrator at risk that it lacks evidence in its administrative record sufficient to rebut a contention raised by a plaintiff participant in a subsequent lawsuit. No evidence of the plan administrator not already present in the administrative record of the benefit claim will be admissible in district court. Remand can no longer be expected to be the remedy for addressing questions raised in court in a particular case as to why the plan administrator interpreted the plan a particular way. A district court is prohibited from considering evidence as to why the plan administrator interpreted the plan as it did unless the evidence was previously introduced into the plan's administrative record of the particular claim in litigation.

To protect the plan and all other plan participants from the diminution of assets occasioned by a decision requiring a plan to pay benefits not truly provided by the plan, plan administrators now have to anticipate during review of a claim all questions that may arise if the claim is denied and litigation follows. This includes (as occurred below) questions later raised by the court's receipt of evidence from a plaintiff participant that was not fully introduced into evidence in the administrative record of that claim. The administrative waste will be significant. Only a tiny fraction of benefit claims ever become the subject of a lawsuit.

The federal courts, the plan administrators and plan participants and beneficiaries all need further guidance from this Court on the extent to which the courts may impose additional claims-handling and adjudication requirements upon the claims processing mechanism established in ERISA and interpreted in the regulations of the U.S. Department of Labor. The magnitude of the need is great. The number of ERISA-regulated defined benefit pension plans alone exceeds 31,000. These plans cover more than 44 million participants and beneficiaries. Over 1600 of these defined benefit pension plans are collectively-bargained, multiemployer pension plans, including the Trust. These multiemployer pension plans cover more than 9.7 million participants and beneficiaries, such as petitioner. Pension Benefit Guaranty Corporation, Pension

Insurance Data Book 2 (2003). Benefit claims review is a never-ending, daily task of the plan administrators of these plans and of the tens of thousands of employee welfare plans covered by ERISA.

A. The Ninth Circuit's Decision Conflicts With Section 503 Of ERISA And Usurps The Authority Granted The Secretary Of Labor By Imposing On The Trust Additional Obligations To Include In The Administrative Record All Evidence That May Possibly Be Needed To Prove To A District Court The Basis For Every Aspect Of The Trust's Determination Of A Benefit Claim And To Rebut All Objections And Contentions That May Be Made In The District Court By A Plaintiff/Participant.

"ERISA was enacted to promote the interest of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113, 109 S.Ct. 948, 956, 103 L.Ed.2d 80 (1989). This Court has noted,

> The Act furthers these aims in part by regulating the manner in which plans process benefits claims. Plans "must provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(1). ERISA further requires that plan procedures "afford a reasonable opportunity . . . for a full and fair review" of dispositions adverse to the claimant. § 1133(2).

Black & Decker Disability Plan v. Nord, 538 U.S. 822, 123 S.Ct. 1965, 1970, 155 L.Ed.2d 1034 (2003).

The Secretary of the Department of Labor ("Secretary"), being charged with the authority to prescribe regulations necessary or appropriate to carrying out ERISA's provisions securing employee benefits, 29 U.S.C.

§ 1135, has set forth minimum standards for what constitutes notice and a "full and fair review" by a multiemployer pension plan. The Secretary requires that a plan administrator provide written or electronic notification of any adverse benefit determination. For pension plans, notice shall be in a manner calculated to be understood by the claimant and shall set forth: "(i) The specific reason or reasons for the adverse determination; (ii) Reference to the specific plan provisions on which the determination is based; (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; [and] (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review." 29 C.F.R. § 2560.503-1(g). A "full and fair review" entails four basic parts: 1. The claimant must be given at least 60 days to appeal an adverse benefit determination; 2. The claimant must have an opportunity to submit "written comments, documents, records, and other information;" 3. The claimant must be given reasonable access to "documents, records, and other information relevant to the claimant's claim for benefits;" and 4. The review of the claim must take into account "all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. § 2560.503-1(h)(2)(i)-(iv). Together, ERISA and these DOL regulations set forth the procedural requirements plan administrators must meet in making claim determinations.

The Trust satisfied these ERISA and DOL requirements in this case. During the appeal of Banuelos' denial of pension benefits, the Trustees had before them the Plan document as they understood it and a quote in a letter from Mr. Weinstock reciting a purported five-year vesting provision on which Banuelos based his claim for benefits. The Trustees denied Banuelos' appeal based on their knowledge that their Plan did not contain the language quoted by Banuelos' attorney and that their Plan did not,

in fact, provide for five-year vesting for participants like Banuelos. Accordingly, Banuelos was notified that his appeal was denied. No claim was made by Banuelos that the Trustees failed in any way to satisfy the full and fair review requirements established by the Secretary.

However, the Ninth Circuit's decision imposes additional requirements far beyond those in ERISA and as adopted by the Secretary in the regulations issued under the authority granted by Congress. Reviewing the Trustees' denial of benefits to Banuelos under the arbitrary and capricious standard, the Ninth Circuit held that the district court was precluded from hearing additional evidence that the five-year vesting amendment had not been adopted, because the proof was not in the administrative record. However, the Trustees knew they had not adopted five-year vesting of the type quoted by Weinstock and had no need to develop an administrative record to establish that no such provision was in effect until the issue was first joined in the district court. By requiring the Trustees to engage in the prophylactic exercise of creating an evidentiary record in Banuelos' appeal over what they knew the Plan to be, the Ninth Circuit imposed notice and review obligations beyond those established by the Secretary.

Given that only the Secretary is empowered to promulgate rules for the administration of ERISA, the ability of the courts to render decisions which infringe upon the power of the Secretary is narrowly circumscribed; "the scope of permissible judicial innovation is narrower in areas where other federal actors are engaged . . . ." *Nord*, 538 U.S. at ___, 123 S.Ct. at 1970-71. The DOL regulations do not require plan administrators to create an administrative record which exhaustively supports the foundation, content and validity of their plan of benefits or their reasons for denying benefits in a particular case. Plan administrators are not even required to set forth or inform a participant of the reasoning on which they base benefit denials:

> The district judge went astray by requiring that the plan administrator articulate the grounds for

> the interpretation in the course of reviewing an adverse determination on a claim for benefits, as if the plan administrator were an administrative agency. There is no such requirement in the law. The administrator must give the "specific reasons" for the denial, but that is not the same thing as the reasoning behind the reasons.... All the [plan administrator] has to do is give the applicant the reason for the denial of benefits; he does not have to explain to him why it is a good reason. To require that would turn plan administrators not just into arbitrators, for arbitrators are not usually required to justify their decisions, but into judges, who are.

Gallo v. Amoco Corp., 102 F.3d 918, 923 (7th Cir. 1996) (citations omitted), *cert. denied*, 521 U.S. 1192 (1997). The regulations only require that the *claimant* be permitted to present records and information, and that any determination consider them. The regulations do not impose on the plan administrator a requirement to submit "comments, documents, records, and other information."

Nord is instructive. In reversing the appellate court's decision, this Court determined that a judicially-imposed "treating physician" rule was not enforceable. The rule required plan administrators to give special weight to the opinions of a claimant's physician over that of non-treating physicians. This Court concluded that the "Court of Appeals therefore erred when it employed a treating physician rule lacking Department of Labor endorsement." 538 U.S. at ___, 123 S.Ct. at 1972. Not only was it lacking Departmental endorsement, but the requirement added by the Ninth Circuit was contrary to the Secretary of Labor's view that "ERISA is best served by 'preserv[ing] the greatest flexibility possible for ... operating claims processing systems consistent with the prudent administration of a plan." *Id.*, citing Department of Labor, Employee Benefits Security Administration, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html, Question B-4 (as visited May 6, 2003).

Even more than the Ninth Circuit's decision in *Nord*, the Ninth Circuit's decision in this case exceeds the power of a court under ERISA. It effectively imposes a requirement that plan administrators create an administrative record for every benefit claim that contains all underlying facts to support their claim determinations, their reasoning, and what their pension or other benefit plan provides, even though few claims ever result in litigation. The Secretary has not imposed this obligation. If review is not granted, this decision will disrupt the operational flexibility and economy of ERISA plans.

B. The Ninth Circuit's Decision Conflicts With the Efficient, Cost-effective, Non-Adversarial System of Claims Administration Of ERISA Expressly Intended by Congress.

Throughout the development of ERISA, administrative efficiency was a primary goal of Congress. Various alternatives were advanced for meeting the need for flexibility in employee benefit determinations. Early proposals authorized the Secretary of Labor to hear and decide benefit claims disputes arising under plans, while later proposals considered requiring plans to provide arbitration.[8] However, these proposals were dropped out of fears that they would be too costly to plans and would encourage frivolous claim disputes.[9] Ultimately, the current, more informal requirement that plans provide a full and fair review by plan fiduciaries was adopted.[10]

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[8] S. 1179, 93d Cong., 1st Sess. § 602 (1973), *reprinted in* Legislative History of the Employee Retirement Income Security Act of 1974 (1976) ("ERISA Leg. Hist."), at 988; S. 4, 93d Cong., 1st Sess. § 691 (1973), ERISA Leg. Hist. at 1489; H.R. 2, 93d Cong., 2d Sess. § 691 (1974), ERISA Leg. Hist. at 3813.

[9] Senate Floor debate on conference report on H.R. 2 (1974), ERISA Leg. Hist. at 4769.

[10] Employee Retirement Income Security Act of 1974 § 503, 29 U.S.C. § 1133 (1974), ERISA Leg. Hist. at 4900.

The benefit claims process was designed to be non-adversarial, efficient, cost-effective, and to reduce the number of frivolous lawsuits that would result so as not to burden the plan's resources held in trust for all of the beneficiaries. *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980). The process was not intended to be a full adjudication of rights akin to a trial. The claims procedure is not even required to operate with the formality or limitations of adversarial proceedings. *Grossmuller v. Int'l Union, et al.*, 715 F.2d 853, 857 (3d Cir. 1983). Instead, it was streamlined to provide the plan with the information necessary to make the correct determination of whether benefits are owed while also informing the participant of the basis for a denial of a benefit claim so that the participant would be sufficiently informed to seek recourse in the courts if he or she so desires.

In support of this scheme, courts adopted the exhaustion requirement under which participants are required to exhaust their administrative remedies before seeking review of a claim denial in federal court. *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980). The exhaustion principle was originally developed under the law governing employee benefit claim actions under Section 301 of the Labor Management Relations Act of 1947 ("LMRA") and then incorporated into ERISA by Congress, which directed that all actions under ERISA to enforce benefit rights be regarded as arising under the laws of the United States in a fashion similar to those brought under Section 301. *Id.*

The clear purpose of the exhaustion requirement was to institutionalize administrative claim procedures within the plans themselves, thereby reducing the number of frivolous lawsuits, promoting consistency of claim determinations, creating a non-adversarial claims settlement process,[11] and minimizing the costs of claims administration. *Id.*

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[11] In fact, from the perspective of multiemployer plans, the benefit determination process is not considered to be adversarial. Plan trustees

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In the case of multiemployer plans, designating plan administrators (the Trustees) as the main repository of claim review and plan interpretation is in keeping with the fundamental nature of employee benefits. The Ninth Circuit's decision interferes with that informal administrative review process by preventing the Trust from addressing Banuelos' evidentiary claims either on remand or by providing rebuttal evidence to the district court to address Banuelos' claims there.

Flexibility in identifying benefit disputes and addressing them on their merits is in the interest of plan administrator review. When it concluded that the administrative record was incomplete as to facts questioning the legitimacy of the five-year vesting provision proffered by *Banuelos*, 382 F.3d at 901, the Ninth Circuit should have remanded the matter back to the Trustees for further consideration. *Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan*, 85 F.3d 455 (9th Cir. 1996) (holding that although trustees of an ERISA plan misconstrued the plan, the district court should not make the benefit determination, but should remand to the plan trustees to apply the plan as properly construed). This is particularly so since the district court was made aware of facts having a bearing on the legitimacy of the plan provision relied on by Banuelos. *See Kosty v. Lewis*, 319 F.2d 744, 749 (D.C. Cir. 1963), *cert. denied*, 375 U.S. 964, 84 S.Ct. 482 (1964).

Remand serves both the congressional mandate that plan administrators be primarily responsible for reviewing participant claims and the obligation of the participant to exhaust his administrative remedies. The Ninth Circuit's

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appointed by labor and by management naturally and routinely seek to find any legitimate means to award benefits to individual participants appearing before them so long as they can do so within the terms of the plan. Of course, this focus is in keeping with the obligations of the trustees as fiduciaries to act for the benefit of the beneficiaries of the plan. *See National Labor Relations Board v. Amax Coal Co.*, 453 U.S. 322, 330-33, 101 S.Ct. 2789, 2794-96 (1981).

refusal to remand creates a new and conflicting precedent that will compel plan administrators to engage in protracted fact-finding at the level of claim review in order to create an administrative record that will withstand potential future attack against the reasoning behind benefit denials. In essence, the two day trial that was conducted in this case in the district court will have to be conducted at the administrative level and for every benefit claim, just in case litigation is ultimately filed. The result: administrative proceedings will become more protracted and administrative costs will increase, or plan administrators will run a risk of being unable to present evidence in support of their benefit determination.

Since the creation of the administrative record will be determinative on appeal, the process will become more adversarial. Participants may be tempted to prevent harmful facts from being included in the administrative record. Here, Banuelos' attorney did not present to the Trustees the purported "plan" document on which he relied, but only quoted a purported five-year vesting provision. It was not until Banuelos attached the purported plan document to his complaint in the district court that the Trustees became aware of it. The unwritten result is to reward the withholding of documents from the administrative record.

C. The Ninth Circuit's Decision That The "No New Evidence Rule" Precludes Consideration Of The Trust's Evidence Challenging The Authenticity Of A Purported Plan Document First Presented In Court Conflicts With ERISA And The Claims Processing Regulations And Misperceives The Scope Of The Rule And Its Principal Applicability To Evidence Proffered By Benefit Claimants.

A general rule has long existed that the district court in an ERISA case is not permitted to consider evidence outside the administrative record when applying the abuse of discretion standard of review to benefit determinations made by the trustees. *Taft v. Equitable Life Assurance*

Society, 9 F.3d 1469, 1471 (9th Cir. 1993). *See also Alford v. DCH Foundation Group Disability Plan*, 311 F.3d 955, 959 (9th Cir. 2002) ("When courts apply the abuse of discretion standard, they *generally* limit review to the record before the plan administrator when making the benefits determination"). Two well-recognized exceptions exist: (1) when a conflict of interest influenced the administrative decision and (2) when the standard of review of the decision is *de novo*. *See Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976-77 (9th Cir. 1999); *Mongeluzo v. Baxter Travenol Disability Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995).

However, the Courts of Appeals have recognized other exceptions. Even the Ninth Circuit has held that a district court may consider evidence outside the administrative record to determine a *threshold* issue. *Tremain v. Bell Industries, Inc.*, 196 F.3d 970, 976-77 (9th Cir. 1999). Thus, in *Tremain*, the court noted:

> In the present case, Tremain offered her evidence from outside the administrative record on a different issue. The issue she presented was whether the plan administrator's conflict of interest affected its decision to deny her benefits. That is a threshold issue which must be decided before a court can determine what standard of review to apply to a plan administrator's benefits decision. Taft does not preclude the consideration of such evidence.

Id. Cf. Hicks v. Pacific Maritime Association, 567 F.2d 335, 358 (9th Cir. 1978) (where the facts appear with such certainty that the trustees could reach but one conclusion, the district court may determine the facts).

The district court's consideration of evidence outside the administrative record under the circumstances of this case is no different. The district court could not determine Banuelos' eligibility for pension benefits until the district court first determined, as a threshold matter, what the Pension Plan provided, which required a determination of whether Exhibit 1, the lawyers' working document, obtained by Weinstock in an earlier matter really was the

Pension Plan. The district court recognized this when it stated: "The issue before the Court is a threshold issue which must be decided *before* the Court reviews the plan administrator's decision for abuse of discretion." App. at 45.

Looking just at the decision below, an exception to the general "no new evidence" rule should apply to the unique circumstances of this case. Failure to recognize an exception would foreclose the Pension Trust from ever challenging the authenticity of a rogue document presented by a pension applicant in support of his request for benefits, unless the rogue document is identified during the appeals process. The Ninth Circuit opinion ignores this fact in holding that the district court committed error in considering evidence that there was a mistake in the purported plan furnished to Weinstock.

Looking more broadly, when the rule against new evidence is applied against the administrator of any ERISA plan, as the Ninth Circuit has done to the Trust in this case, the goal of supporting an efficient, flexible administrative claim review process is not served, and the rule conflicts with ERISA and with the claims processing regulations. Applied against a participant, the rule makes sense. It requires the participant to provide all information that a plan administrator may need to review to consider fully and fairly the participant's claim. Applied against a plan administrator, the rule requires the unnecessary and inefficient expenditure of resources to create a record not for the full and fair review of the participant's claim but to enable the plan administrator to protect against possible future claims in the district courts.

The DOL guidelines do not suggest the Trustees be denied an opportunity to show why they interpreted the Plan as they did. Indeed, the emphasis of the DOL's full and fair review requirement is on providing the participant with an access to information, an opportunity for the participant to present evidence, and ensuring the participant's evidence is considered at the administrative level. 29 C.F.R. § 2560.503-1(h)(2)(i)-(iv). The Ninth Circuit's

opinion is contrary to the DOL's guidelines in that it places the burden on an ERISA plan administrator to submit evidence to itself at the administrative level.

No valid reason exists for applying the rule against introduction of new evidence to plan administrators since the participant is not harmed if relevant evidence is not included by the administrator in the administrative record. First, the administrator nevertheless remains under the obligation to provide notice and a "full and fair review" which includes providing participants with a statement of the specific reasons for any denial of benefits. 29 C.F.R. § 2560.503-1(g). This guarantees that the participant is informed of the basis for the denial and arms the participant with the necessary knowledge to determine whether to seek recourse in the district court. *Matuszak v. Torrington Co.*, 927 F.2d 320, 323 (7th Cir. 1991).[12] Second, if the participant is successful and the court determines that he or she is entitled to benefits, the participant can obtain retroactive benefits, interest, and any attorney's fees incurred in bringing the claim in the district court. 29 U.S.C. § 1132(g). Thus, the participant is made whole.

D. The Decision Of The Ninth Circuit To Award A Pension Benefit Never Promised Or Adopted By The Trust Exceeds The Jurisdiction Of The Court Under Section 502 Of ERISA To Award Benefits Under The Terms Of The Pension Plan Of The Trust.

Section 502(a)(1)(B) of ERISA permits a participant to sue:

---

[12] Permitting plan administrators to submit evidence in the district court that was not part of the administrative record is different from permitting a plan administrator to raise in the district court new reasons for the denial of benefits which was not conveyed to the participant at the time of administrative appeal. The latter violates the participant's right to a full and fair review and would "emasculate ERISA's disclosure requirement." *Matuszak*, 927 F.2d at 323.

> To recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B). The courts, in turn, are permitted to fashion appropriate equitable relief, including the award of benefits due under the terms of the plan. However, the courts are not empowered to award compensatory or punitive damages under ERISA. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 144-48, 105 S.Ct 3085, 87 L.Ed.2d 96 (1985).

The Ninth Circuit awarded a pension benefit to Banuelos that was never promised by or adopted by the Trust. Thus, the court's award to Banuelos of this benefit was an award of damages rather than an award allowing Banuelos "to recover benefits due to him under the terms of his plan." The court's order to Banuelos was, in essence, a sanction imposed against the Trust for its lack of foresight in not having anticipated the arguments Banuelos would make in court and having placed all documents and testimony needed to defeat Banuelos' claims into the administrative record.

III.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Ninth Circuit.

Respectfully submitted,

JOHN S. MILLER, JR.
CHARLES E. NONEMAN
COX, CASTLE & NICHOLSON LLP
2049 Century Park East
Twenty-Eighth Floor
Los Angeles, California 90067-3284
(310) 277-4222

Eijinio BANUELOS

Plaintiff-Appellant,

v.

CONSTRUCTION LABORERS' TRUST FUNDS FOR SOUTHERN CALIFORNIA,
Defendant-Appellee.

No. 02-57096.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted Feb. 11, 2004.

Filed Aug. 24, 2004.

Richard A. Weinstock, Ventura, CA, for the appellant.

Charles E. Noneman, Los Angeles, CA, for the appellee.

Appeal from the United States District Court for the Central District of California; Robert J. Kelleher, Senior Judge, Presiding. D.C. No. CV-00-05630-RJK.

Before B. FLETCHER, PREGERSON, and BRUNETTI, Circuit Judges.

BRUNETTI, Circuit Judge:

Eijinio Banuelos ("Banuelos") filed the underlying complaint against the Construction Laborers' Pension Trust for Southern California ("the Trust"), seeking to establish his right to receive a pension. The district court denied the parties' cross-motions for summary judgment, relying on evidence that was not part of the administrative record to conclude that there was a genuine issue of material fact as to whether the Trust had adopted five-year vesting rules applicable to Banuelos. After a bench

trial, the district court held that Banuelos was not entitled to five-year vesting.

Banuelos appeals the district court's denial of his summary judgment motion, arguing that the district court erred by considering evidence outside the administrative record. We reverse the denial of Banuelos's motion for summary judgment, vacate the subsequent judgment, and remand to the district court with instructions to remand to the plan administrator to calculate Banuelos's pension.

I

FACTS AND PROCEEDINGS BELOW

A. The Pension Plan

The Trust is an express trust established in 1962. Pursuant to the terms of various collective bargaining agreements between the Southern California District Council of Laborers and numerous employers' associations, the Trust created and maintained a pension plan. The plan is a multi-employer defined benefit pension plan within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Banuelos's right to a pension is governed by the provisions of the pension plan. Banuelos is a retired construction laborer who worked within the area covered by the Trust from 1966 to 1991. He retired from the construction field in 1992 and on January 23, 1995, he turned 65.

When Banuelos retired, the pension plan provided for three different forms of regular pension. Plan One provided for those people who have completed at least 10 years of credited service; Plan Two for those who completed at

least 15 years of credited service; and Plan Three for those who completed at least 25 years of credited service. The plan sets forth the applicable "break in service" rules and specifies how credits are to be calculated. A worker is credited with one year of service for each year in which he was employed more than 1000 hours. A "break in service" occurs in each calendar year during which the worker completed fewer than 501 hours of service. The undisputed facts show that Banuelos's years of credited service total no fewer than six years and no more than seven years under any applicable "break in service" rules.

When Banuelos retired, a minimum of 10 credited years were required for a vested pension. In September 1998, however, in a separate lawsuit involving a different worker, Banuelos's attorney received from the Trust a copy of the apparently then-applicable pension plan. The cover-page of that plan states it is the plan's version "[a]s amended to June 30, 1994." Section 4.07(e) of that 1994 version of the plan specifies that only five credited years of service are required for a vested pension. Section 4.07(e) of the 1994 version of the plan provides that:

> an employee who (i) has accumulated five years of Credited Service computed as provided in Section 4.04A and 4.06, (ii) is 65 years or older, and (iii) has not had a break in service during the period referenced in (i) above shall have a vested pension.

According to a footnote in this 1994 version of the plan, the change was made retroactive to January 1, 1988. Because Banuelos did not retire until 1992, section 4.07(e), if valid, would apply to him.

B. Banuelos's Pension Application

In August of 1999, Banuelos submitted an application for a pension to the Trust through his attorney. The plan administrator issued a conditional approval based on its calculation that Banuelos had earned six years of vesting credit. How [sic] because of several one-year breaks in service beginning in 1990, the administrator would not recognize any of the pre-1990 credit years unless Banuelos complied with the Trust's credit year reinstatement provisions which required him to work 501 more hours.

Citing the five-year vesting language of section 4.07(e) of the 1994 version of the plan, Banuelos appealed the administrator's computation of his credit hours and his amount of conditional benefits. The Pension Appeals Committee denied Banuelos's appeal.

On May 24, 2000, Banuelos brought this action, seeking declaratory relief and damages for violations of ERISA and the Age Discrimination in Employment Act. Banuelos subsequently dropped his Age Discrimination in Employment Act claim.

C. The Denial of the Summary Judgment Motions

Both parties filed summary judgment motions. In its motion for summary judgment, the Trust alleged that the 1994 version of the plan upon which Banuelos based his suit was an incorrect version of the pension plan. The Trust alleged that the amendment Banuelos's attorney received – containing section 4.07(e) – was considered by the board at one time but was never adopted. The Trust further alleged that Banuelos's attorney received the unadopted amendment because it accidentally was compiled with the true plan. The cover letter accompanying

the plan given to Banuelos's attorney from the Trust, however, stated that enclosed was "the Construction Laborers Pension Document, Summary Plan Description dated May 1979 with enclosed blue insert on amendments through 1986, plus amendments through 1997."

Clearly, evidence of this mistake was not in the administrative record before the plan administrator because the alleged mistake was not discovered until after the plan administrator had made its decision. Moreover, the district court found as undisputed fact that the "trust's mistake claim" and "the evidence in support thereof are not part of the administrative record."

In Banuelos's summary judgment motion he argued that pursuant to section 4.07(e) of the 1994 version of the plan, he was entitled to a pension. The district court denied both parties' motions. Relying on evidence outside the administrative record, the district court concluded that there was a triable issue of material fact as to whether section 4.07(e) of the 1994 version of the plan was part of the Trust plan.

After a bench trial, the district court determined that section 4.07(e) of the 1994 version of the plan was not part of the Trust's plan. The district court remanded the case to the plan administrator to determine if Banuelos would be entitled to benefits on the basis of the plan without section 4.07(e). Banuelos appeals the district court's denial of his summary judgment motion. Banuelos asserts that the district court erred by considering evidence outside the administrative record, and without that evidence he is entitled to a pension under section 4.07(e) as a matter of law.

II

STANDARD OF REVIEW

A district court's decision to deny a summary judgment motion is reviewed de novo. *Brewster v. Shasta County,* 275 F.3d 803, 806 (9th Cir.2001). This Court must determine, viewing the evidence in the light most favorable to the non-moving party, whether there are any genuine issues of material fact and whether the district court correctly applied the relevant substantive law. *United States v. City of Tacoma,* 332 F.3d 574, 578 (9th Cir.2003).

III

JURISDICTION

The Trust argues that we do not have jurisdiction over Banuelos's appeal because (1) Banuelos is appealing the district court's order denying his summary judgment motion after a full trial on the merits, and (2) there has been no final order because the district court only remanded the suit to the plan administrator to determine Banuelos's benefits under the correct version of the plan. The Trust is correct that generally this court will not review a denial of a summary judgment motion after a full trial on the merits. *Locricchio v. Legal Services Corp.,* 833 F.2d 1352, 1359 (9th Cir.1987) (finding "that the denial of a motion for summary judgment is not reviewable on an appeal from the final judgment after a full trial on the merits"). This is because "[o]rdinarily a denial of a motion for summary judgment is not a final order and thus not appealable." *Abend v. MCA, Inc.,* 863 F.2d 1465, 1482 n. 20 (9th Cir.1988).

This general rule, however, does not apply to those denials of summary judgment motions where the district court made an error of law that, if not made, would have required the district court to grant the motion. *Pavon v. Swift Transp. Co., Inc.,* 192 F.3d 902, 906 (9th Cir.1999). In *Pavon* the plaintiff sued his former employer in state court for unpaid wages. This suit was dismissed following a settlement. *Id.* The plaintiff then sued his former employer in federal court for race discrimination. The employer moved for summary judgment based on the doctrine of claim preclusion. *Id.* The district court denied the motion. After a trial on the merits the jury awarded Pavon damages. Despite there already being a full trial on the merits, this court reviewed the denial of the summary judgment motion. *Id.*

In *Pavon,* we first stated the general rule that "this court will often decline to engage in the 'pointless academic exercise' of reviewing a denial of summary judgment after a trial on the merits." *Id.* (citing *Lum v. City and County of Honolulu,* 963 F.2d 1167, 1169-70 (9th Cir.1992)). We concluded that "such a case is not presented here, because the question of claim preclusion was not a disputed factual issue that went to the jury, but was a ruling by the district court on an issue of law." *Id.* This distinction is logical. If a district court denies a motion for summary judgment on the basis of a question of law that would have negated the need for a trial, this court should review that decision. If, however, a district court denied a motion for summary judgment based on a disputed issue of fact, and that issue of fact was decided in a subsequent trial, this court will not engage in the pointless academic exercise of deciding whether a factual issue was disputed after it has been decided.

Similarly, in *Wilson Arlington Co. v. Prudential Ins. Co.*, 912 F.2d 366 (9th Cir.1990), we reversed a denial of a summary judgment motion after a trial on the merits. In *Wilson,* we held that the district court erred in considering parole evidence that was inadmissible under the applicable state law, and that without the evidence admitted in error, there was no triable issue of fact. *Id.* at 372-73. *Wilson* is instructive in this case.

Essentially, Banuelos argues that the district court erred as a matter of law when it concluded it could hear evidence outside the administrative record. Because it was evidence outside the administrative record that created a disputed issue of material fact, Banuelos argues, the legal error resulted in the district court wrongly denying his summary judgment motion. Banuelos asserts that because he is appealing the district court's erroneous legal conclusion, this court has jurisdiction to hear the appeal. Banuelos's argument is persuasive.

The Trust next asserts that we do not have jurisdiction to hear this appeal because no judgment has been entered by the district court since the district court only remanded the case to the plan administrator to determine Banuelos's benefits. The Trust's assertion is unpersuasive. The district court's order remanding to the plan administrator is an appealable final order under *Hensley v. Northwest Permanente P.C. Ret. Plan & Trust,* 258 F.3d 986, 993 (9th Cir.2001). Under *Hensley,* an order remanding a case to an ERISA plan administrator is appealable only when: (1) the district court order conclusively resolved a separable legal issue, (2) the remand order forces the agency to apply a potentially erroneous rule which may result in a wasted proceeding, and (3) review would, as a practical matter, be foreclosed if an immediate appeal

were unavailable. *Id.* (quoting *Williamson v. UNUM Life Ins. Co. of Am.*, 160 F.3d 1247, 1251 (9th Cir.1998)).

Here, the test has been met: (1) the district court decided a separable legal issue – whether it could hear evidence outside the administrative record of the Trust's mistake in compiling the 1994 version of the plan; (2) remand would result in a wasted proceeding if Banuelos is correct about the applicable pension plan; and (3) there is no other way, as a practical matter, for Banuelos to challenge the applicable pension plan. Accordingly, we have jurisdiction to hear this appeal under 28 U.S.C. § 1291.

IV

ANALYSIS

A. Evidence Outside the Administrative Record

Banuelos argues that the district court's decision to hear evidence of the Trust's mistake at trial was erroneous because that evidence was not presented to the plan administrator. While the district court stated that its "review is generally limited to the administrative record," it noted that "evidence outside the administrative record may be considered in limited circumstances." The district court held that because it was hearing evidence to determine whether section 4.07(e) of the 1994 version of the plan actually was adopted, the general rule limiting its review to the administrative record did not apply. This was in error.

Where, as here, an ERISA plan vests the administrator with discretionary authority to determine benefit eligibility, the district court reviews the administrator's determinations for abuse of discretion. *Firestone Tire &*

Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). This court has clearly established that "the abuse of discretion standard permits the district court to 'review only the evidence presented to the [plan] trustees.'" *Taft v. Equitable Life Assurance Soc'y,* 9 F.3d 1469, 1471 (9th Cir.1993) (alteration in the original) (quoting *Jones v. Laborers Health & Welfare Trust Fund,* 906 F.2d 480, 482 (9th Cir.1990)). "[T]his conclusion is consistent with the nature of abuse of discretion review, furthers the goals of ERISA, and is in line with the decisions of nearly every other circuit to consider the issue." *Id.*

We note, however, that there are two exceptions to this general rule that a district court may not hear evidence outside the administrative record. First, a district court may hear such evidence when the court must determine if a plan administrator's decision was affected by a conflict of interest. *Tremain v. Bell Indus., Inc.,* 196 F.3d 970, 976-77 (9th Cir.1999). Second, the court can hear evidence outside the administrative record when the standard of review of the administrative decision is de novo. *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan,* 46 F.3d 938, 943-44 (9th Cir.1995). Because this case does not invoke either of these two exceptions, the district court erred as a matter of law in concluding it could hear evidence outside the administrative record.

B. Banuelos's Summary Judgment Motion

Courts will generally bind ERISA defendants to the more employee-favorable of two conflicting documents – even if one is erroneous. *See Bergt v. Ret. Plan for Pilots Employed By MarkAir, Inc.*, 293 F.3d 1139 (9th Cir.2002). This is because

> Any burden of uncertainty created by careless or inaccurate drafting . . . must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask.

Id. at 1145 (quoting *Hansen v. Cont'l Ins. Co.*, 940 F.2d 971, 982 (5th Cir.1991)). Here, the court is presented with two plans. One plan includes the five-year vesting provision, while the other does not. Because the ERISA plan that includes the five-year vesting provision is more favorable to Banuelos than the plan without the provision, this court must determine whether, as a matter of law, Banuelos is entitled to a pension under the plan that includes the five-year vesting provision.

Limiting consideration to the evidence in the administrative record, Banuelos's summary judgment motion should have been granted. As previously noted, section 4.07(e) provides that an employee who has accumulated five years of credited service is entitled to a pension. It is undisputed that Banuelos's years of credited service total no fewer than six years and no more than seven years. The plan administrator erred in concluding that Banuelos must work 501 more hours to receive his pension because of his 1990 break in service. This break in service occurred after Banuelos had completed the five years of service required for vesting. Once an employee has completed the required service for vesting, a subsequent break in service cannot deprive the employee of benefits. *See Nachman Corp. v. Pension Ben. Guaranty Corp.*, 446 U.S. 359, 378 n. 27, 100 S.Ct. 1723, 64 L.Ed.2d 354 (stating that the

vesting of a pension means that the receiving of a pension is no longer contingent upon remaining in the employer's service); *see also Martin v. Constr. Laborer's Pension Trust for S. Cal.*, 947 F.2d 1381, 1383 (9th Cir.1991) (stating that the pension plan's break-in-service rules applied only until the worker completed the service required for vesting); *Bolton v. Constr. Laborers' Pension Trust for S. Cal.*, 954 F.2d 1437, 1438 (stating that the pension plan's break-in-service rules allowed cancellation of a non-vested participant's credited service).

Because Banuelos completed the required service for vesting and his post-vesting breaks in service do not affect his pension entitlement, Banuelos is entitled to a pension as a matter of law.

V

CONCLUSION

We hold that the district court erred by concluding it could hear evidence that was not in the administrative record. Had the district court only looked at evidence within the administrative record, it necessarily would have granted Banuelos's summary judgment motion. Accordingly, we reverse the district court's denial of Banuelos's summary judgment motion, vacate the subsequent judgment, and remand to the district court with instructions to remand to the plan administrator to calculate Banuelos's pension.

REVERSED. VACATED, and REMANDED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

EIJINIO BANUELOS, Plaintiff-Appellant, v. CONSTRUCTION LABORERS TRUST FUNDS FOR SOUTHERN CALIFORNIA, Defendant-Appellee.	No. 02-57096 D.C. No. CV-00-05630-RJK **JUDGMENT**

Appeal from the United States District Court for the Central District of California, Los Angeles.

This cause came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

On consideration whereof, it is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is **REVERSED**.

Filed and entered Tuesday, August 24, 2004

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

EIJINIO BANUELOS, Plaintiff, v. CONSTRUCTION LABORERS' PENSION TRUST FOR SOUTHERN CALIFORNIA Defendants.	Case No. CV 00-05630 RJK (Ex) **FINDINGS OF FACT AND CONCLUSIONS OF LAW; ORDER THEREON** (Filed Nov. 8, 2002)

This action came on regularly for bench trial before the Honorable Robert J. Kelleher on August 21, 2002, with Plaintiff Eijinio Banuelos and Defendant Construction Laborers' Pension Trust For Southern California present; the Court, having heard the evidence, finds the facts and states the conclusions of law as follows:

FINDINGS OF FACT

1. Defendant Construction Laborers Pension Trust for Southern California ("CLPT") is an express trust established effective June 15, 1962, pursuant to a written Agreement and Declaration of Trust ("Trust Agreement") executed on October 16, 1962; The CLPT is established pursuant to § 302 (c)(5) of the Labor Management Relations Act of 1947, as amended (29 U.S.C. § 186 (c)(5));

2. The Trust Agreement is a product of collective bargaining negotiations between the Southern California District Council of Laborers ("District Council") and certain employers' associations.

3. Pursuant to the terms of various collective bargaining agreements between the District Council and certain employers' associations, the Trust created and maintained a Pension Plan.

4. This Pension Plan is a multiemployer defined benefit Pension Plan within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001, et seq.;

5. Plaintiff Eijinio Banuelos is a retired construction laborer. Plaintiff worked as a construction laborer within the area covered by the CLPT for 25 years from 1966 to 1991.

6. Throughout his employment, Banuelos was a member of Laborers Local 585, a local union affiliated with the District Council.

7. The CLPT is governed by The Board of Trustees. Half of the members of The Board of Trustees are appointed by the District Council and half are appointed by the employers' associations;

8. The Trust Agreement establishing the CLPT provides, *inter alia*,:

> 5.20 Functions, Powers, and Duties of Trustees,
>
> (a) . . .
>
> (b) The Board of Trustees shall have the power to administer the Fund and to administer and maintain the Pension Plan in effect, having and performing all powers and duties reasonably necessary to maintain and operate the Plan in such a way as to accomplish its objectives . . . Consistent with the foregoing, the Board of Trustees shall have the power to interpret the Plan of Benefits

as it exists, has existed, or may exist, from time to time, and its interpretation shall be final and binding upon all interested parties.

9. Pursuant to Article IX, § 9.01 of the Trust Agreement, amendments to the Pension Plan may only be adopted, *inter alia,* following a second reading of the amendment at a Board of Trustees meeting.

10. The Board of Trustees adopted a Pension Plan ("Plan") providing for the payment of retirement benefits to eligible employees. Plan One governs those employees who have completed at least ten years of credited service after June 15, 1962. Generally, a participant is credited with one year of service for each year in which he was employed for more than 1000 hours. The participant must have completed 3 of the said years of credited service after December 31, 1970. Furthermore, the participant must have attained Normal Retirement Age and worked in Covered Employment for at least 700 hours following the date with respect to which contributions are first made for him.

11. As originally adopted, "Normal Retirement Age" was age 65, or the age on the 10th anniversary of the employee's commencement of participation in the Plan, whichever is later.

12. In response to the gradual liberalization of ERISA's vesting requirements and definitions of Normal Retirement Age, the Trustees amended the Plan One pension and related provisions of the Pension Plan on several occasions.

13. In response to the Tax Reform Act of 1988, the Trustees adopted Amendment No. 90-2-P in

1990, providing a five-year vesting period for employees who were not covered by applicable collective bargaining agreements. Amended No. 90-2-P modified subsection [sic] § 4.07 of the Plan as follows:

> Effective January 1, 1989, any Employee who has accumulated five years of credited service in employment not covered by a Collective Bargaining Agreement computed as provided in Sections 4.04A and 4.06 shall have a vested pension, provided the Employee completed one or more Hours of service on or after January 1, 1988.

14. Banuelos was covered by applicable collective bargaining agreements. Accordingly, his rights under the Plan were not affected by Amendment No. 90-2-P.

15. The Trustees adopted Amendment No. 93-1-P in response to the Omnibus Budget Reconciliation Act of 1989.

16. The first two-page version of Amendment No. 93-1-P was presented for a first reading at the February 23, 1993 Board of Trustees' meeting. This version indicated an effective date of January 1, 1993.

17. The minutes from the February 23, 1993 Board of Trustees' meeting described the content of Amendment No. 93-1-P as follows:

> Motion made, seconded and carried to approve the first reading of Amendment No. 93-1-P which would amend the number of hours required for years of credited service for vesting purposes

under the 10 year plan under § 2.02.A of Plan 1 of Art. II, and add a § 4.07(e) of Article IV which provides for a pension with 5 years of credited service for a person who reaches age 65 or older.

18. The first version of Amendment No. 93-1-P would have provided five-year vesting to all participants age 65 or older in the Pension Plan. The adoption of the first version of Amendment No. 93-1-P would have presented a significant actuarial cost to the pension fund.

19. It was the practice of the Trustees to direct the CLPT's actuarial consultant to prepare an analysis of the cost of amendments that would liberalize benefits.

20. The Trustees did not direct the CLPT's actuarial consultant to prepare an analysis of the cost of adopting the first version of Amendment No. 93-1-P.

21. The 1983-1986 collective bargaining agreements between the District Council and the employers' associations prohibited the Trustees from improving benefits under the Pension Plan (unless mandated by law).

22. The first version of Amendment No. 93-1-P would have, within the meaning of the collective bargaining agreements, improved benefits under the Pension Plan.

23. Amendment No. 93-1-P was revised between its first and second readings. The revised version of Amendment No. 93-1-P was presented for second reading at the Trustees' meeting on April 13, 1993, and was approved by the Trustees. The

second version of the Amendment No. 93-1-P indicated an effective date of January 1, 1988.

24. The revised version of Amendment No. 93-1-P presented to the Trustees during the April 13, 1993 meeting deleted the provision providing five-year vesting for employees covered by collective bargaining agreements.

25. The revised version of Amendment No. 93-1-P amended, *inter alia,* the Normal Retirement Age as follows:

> The term "Normal Retirement Age" as the term is used in ERISA means the later of age 65, or, if the employee worked one or more hours after January 1, 1988, the Employee's age on the fifth anniversary of the Employee's commencement of participation in the Plan.

26. With respect to describing the content of the second version of Amendment No. 93-1-P, the minutes of the April 13, 1993 Trustees' meeting repeated the language from the minutes of the February 23, 1993 Trustees' meeting.

27. The description of Amendment No. 93-1-P in the minutes from the April 13, 1993 meeting was mistakenly drafted.

28. On June 8, 1993 the Trustees mistakenly approved the April 13, 1993 minutes that contained the erroneous description of Amendment No. 93-1-P.

29. Amendment No. 93-1-P, ratified by the Trustees at the April 13, 1993 meeting, did not affect Plaintiff's rights, as the Plan specified a normal retirement age of 65, which was later than the

fifth anniversary of Banuelos' participation in the Plan.

30. Both versions of Amendment No. 93-1-P indicate that they had a first reading in February 1993 and a second reading in April 1993. To the extent copies of the first version of Amendment No. 93-1-P indicate that the first version had a second reading in April of 1993, such copies are mistaken.

31. In 1993 the Trustees never intended to amend the Pension Plan to provide five-year vesting for participants covered by collective bargaining agreements.

32. The Trustees did not understand or believe that Amendment No. 93-1-P, as adopted, provided for five-year vesting for participants covered by collective bargaining agreements.

33. Adoption of § 4.07(e) would have extended five-year vesting to employees covered by collective bargaining agreements and, therefore, would have required the Trustees to obtain the approval of the collective bargaining parties.

34. The Trustees have consistently interpreted the Plan not to provide five-year vesting for participants like Banuelos (until the effective date of Amendment No. 98-4-P).

35. In 1995, the Trustees adopted Amendment No. 95-6-P, which added § 4.07(f) to the Plan, as follows:

> (f) upon attainment of Normal Retirement Age, unless such right has vested earlier, an Employee shall have a right to a vested pension, subject to

> the other terms and conditions of the Plan.

36. In 1998, in response to the expanded five-year vesting requirements of the Small Business Job Protection Act of 1996, the Trustees adopted Amendment No. 98-4-P, which provided as follows:

> Effective January 1, 1998, any Employee who has accumulated five years of credited service in employment covered by a Collective Bargaining Agreement computed as provided in Sections 4.04A and 4.06 shall have a vested pension, provided the Employee completed one or more Hours of Service on or after January 1, 1998.

37. Amendment No. 98-4-P extended five-year vesting to all participants in the Pension Plan for hours worked after January 1, 1998.

38. In 1977, the Board of Trustees adopted an amended and restated Pension Plan which brought the Plan into conformity with ERISA. The Pension Plan was formally restated in a booklet dated November 1977.

39. The 1977 Pension Plan has been amended many times since it was adopted. In May of 1979, the Board of Trustees published an updated version of the Pension Plan, which incorporated amendments to the Plan through Amendment No. 79-0-P.

40. After the May I979 printing of the Pension Plan, the Trustees updated the Plan by way of supplements to the May 1979 Plan, the last of which was prepared in 1986.

41. For some time prior to 1993, the CLPT's legal co-counsel maintained a compilation of the Plan, which attempted to update the original November 1977 Pension Plan booklet. Co-counsel's compilation was created and maintained principally for use by co-counsel, and it was never adopted as the Pension Plan by the Board of Trustees.

42. Co-Counsel would update their compilation from time to time to reflect their understanding of amendments which had been made to the Pension Plan.

43. A copy of the compilation maintained by co-counsel was periodically furnished to the Administrative Office of the CLPT as a reference tool. Co-counsel did not intend the compilation to be distributed to third parties not involved with the administration of the CLPT.

44. During 1993, Reich, Adell & Crost, labor co-counsel to the CLPT, updated the plan compilation maintained by co-counsel.

45. When Reich, Adell & Crost updated the plan compilation with the amendments from 1993, portions of both versions of Amendment No. 93-1-P were included. In particular, co-counsel's compilation included the following:

    A. The amendment of § 1.20 of the Pension Plan with language from the second version of Amendment No. 93-1-P.

    B. The amendment of § 7.11 of the Pension Plan with language from the second version of Amendment No. 93-1-P.

C. The amendment adding Section 4.07(e) to the Pension Plan with language from the first version of Amendment No. 93-1-P.

The portion of the first version of Amendment No. 93-1-P amending § 2.02 A of the Pension Plan was not incorporated in the updated plan compilation.

46. The footnotes contained in co-counsel's compilation indicated that the above changes were made by Amendment No. 93-1-P, and that the effective date of the above changes was January 1, 1988 (even though the first version of Amendment No. 93-1-P indicated an effective date of January 1, 1993).

47. The inclusion of provisions from the first version of Amendment No. 93-1-P in co-counsel's compilation of the plan was a mistake.

48. In late 1993 or early 1994, Reich, Adell & Crost sent a copy of the disk containing co-counsel's compilation to Cox, Castle & Nicholson, management co-counsel. The compilation copy contained mistakes including portions of the first version of Amendment 93-1-P. As Cox, Castle, & Nicholson updated the compilation, the mistakes relating to Amendment No. 93-1-P perpetuated themselves, until their eventual discovery.

49. Sometime after June 30, 1994, Cox, Castle & Nicholson updated co-counsel's compilation of the plan with amendments through Amendment No. 94-2-P (the "1994 compilation"). A copy of the 1994 Compilation was furnished to Robert Glaza, the Plan's Administrator. Rochelle Asheroff, the Pension Supervisor for the CLPT, obtained a copy of the 1994 Compilation.

50. In September 1998, in connection with his representation of another participant in the CLPT, Richard Weinstock, counsel for Banuelos, requested the CLPT to furnish him with a copy of the initial Pension Plan plus all modifications.

51. In response, Ms. Asheroff sent Mr. Weinstock a copy of the May 1979 Pension Plan booklet, an insert containing amendments through 1986, the amendments to the Plan, and a copy of the 1994 Compilation, which included the mistakes relating to Amendment No. 93-1-P.

52. On or about August 26, 1999, Banuelos submitted a pension application to the CLPT through Mr. Weinstock.

53. In November 1999, The Administrative Office prepared a pension summary for Banuelos ("Additional Credit Summary"). The Additional Credit Summary reflected that Banuelos incurred several one-year breaks in service beginning in 1990 that continued until he reached age 65 in 1995. The Additional Credit Summary conditioned benefits upon Banuelos' completion of 501 hours of work or proof of continuous social security benefits.

54. By letter dated November 29, 1999, the Administrative Office advised Mr. Weinstock that Banuelos' pension application had been conditionally approved pending Banuelos' completion of 501 or more hours of work in covered employment. The approval was based on the effect of Amendment No. 95-6-P and granted conditional vesting credit of six years and conditional benefit credit of 5 and 8/12 years, subject to returning to work for 501 hours or more.

55. Banuelos did not return to work in covered employment.

56. Banuelos appealed the CLPT's decision by letter dated December 27, 1999 and specifically cited § 4.07(e) in support of his appeal.

57. The Pension Appeals Committee of the CLPT considered Banuelos' appeal at its meeting on January 17, 2000, and denied his appeal.

58. The Administrative Office advised My. [sic] Weinstock of the denial of Banuelos' appeal by letter dated January 25, 2000.

59. Sometime in early 2000, John S. Miller, Jr., of Cox, Castle & Nicholson became aware of the five-year vesting provision contained in § 4.07(e) of the plan compilation maintained by co-counsel.

60. Thereafter, Cox, Castle & Nicholson attempted to determine why § 4.07(e) was contained in co-counsel's compilation.

61. In 2000, co-counsel recommended that the Trustees clarify Amendment No. 93-1-P. Accordingly, co-counsel drafted Amendment No. 00-01-P, the subject of which was, in pertinent part, "Clarification of Amendment No. 93-1-P."

62. On April 18, 2000, the Trustees adopted Amendment No. 00-01-P, part of which deleted § 4.07(e) as it appeared in co-counsel's plan compilation. At the time, neither co-counsel nor the Trustees were aware that § 4.07(e) was included in the compilation maintained by co-counsel as a result of error.

63. During the last quarter of 2000, Cox, Castle & Nicholson assumed responsibility for reviewing and updating the draft of the Summary Plan

Description of the Pension Plan. In connection with this process, Cox, Castle & Nicholson began a comprehensive review of the Pension Plan, beginning with the original restated Pension Plan dated November 1977 and continuing with a review of all amendments to the Plan to assure that the language of each amendment was incorporated into the Pension Plan accurately.

64. During the process of reviewing and updating the Pension Plan, certain discrepancies were identified relating to Amendment No. 93-1-P. In particular, it was discovered that there were two versions of the Amendment, both indicating that they had been adopted, and that co-counsel's compilation of the plan reflected the inclusion of portions of both versions of Amendment 93-1-P.

65. Upon review of the minutes, correspondences, and agendas, it was revealed that only the second version of Amendment No. 93-1-P had been adopted by the Trustees, and that § 4.07(e) as contained in Amendment No. 93-1-P was never a part of the Plan. This was discovered during March 2001, and counsel advised Mr. Weinstock of the mistake.

66. Plaintiff did not rely on the 1994 Compilation containing the mistakes relating to Amendment No. 93-1-P when he retired in 1992, or at any time thereafter.

CONCLUSIONS OF LAW

1. The Trust Agreement vests the Trustees with the power to administer the Trust, and the power to interpret and apply the Plan. *See, e.g. Canseco v. Construction Laborers Pension Trust for Southern California*, 93 F.3d 600, 605 (9th Cir. 1996).

Accordingly, the Court may set aside the Trustees' determination that Banuelos was not entitled to benefits only if it was arbitrary, capricious, in bad faith, not supported by substantial evidence, or contrary to law. *Id.*; *See also Music v. Western Conference of Teamsters.* 712 F.2d 413, 418 (9th Cir. 1983) (internal quotations omitted.)

2. The Trustees' power to interpret and apply the Trust Agreement extends to their procedure of having amendments to the Plan presented for a "first reading" (whether in writing or not), directing that the amendment then be prepared in writing (or revised) prior to a "second reading", and adopting the amendment at the "second reading" when it was in final written form.

3. The content of the Pension Plan is to be determined from the source documents – in this case, the 1977 Pension Plan as changed by amendments duly adopted by the Board of Trustees.

4. § 402(a) of ERISA requires that "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument." 29 U.S.C. § 1102(a). *See also Cinelli v. Security Pacific Corp.* 61 F.3d 1437, 1441 (9th Cir. 1995).

5. The Omnibus Budget Reconciliation Act of 1989 ("OBRA '89"), which prompted co-counsel to prepare Amendment No. 93-1-P, did not require any amendment to the Plan's vesting provisions. OBRA '89 required a modification of the Plan's definition of Normal Retirement Age.

6. The Trustees never adopted the first version of Amendment No. 93-1-P, purportedly lowering the vesting period to five years for employees covered

by collective bargaining agreements. This version only had a first reading.

7. The Trustees adopted only the second version of Amendment No. 93-1-P, which did not add five-year vesting to the Pension Plan.

8. Banuelos cannot rest his claim for benefits based on the mistakes that were made in the handling of the records relating to Amendment No. 93-1-P. *Cinelli,* 61 F.3d at 1445.

9. Banuelos cannot rest his claim for benefits on the doctrine of estoppel. Common law theories of estoppel are pre-empted by ERISA. *Aetna Life Ins. Co. v. Bayona,* 223 F.3d 1030, 1034 (9th Cir. 2000) (citing *Ellenburg v. Brockway, Inc.*, 763 F.2d 1091, 1095 (9th Cir. 1985.)) While some courts have applied estoppel to pension plans (see *id.* at 1096) Banuelos cannot satisfy one of the essential elements for applying the doctrine of estoppel. Specifically, Banuelos never relied to his detriment on the mistakes contained in the 1994 pension plan compilation maintained by co-counsel. *Id.*

10. Ms. Asheroff's distribution of co-counsel's 1994 compilation to Mr. Weinstock was not binding on the Trustees. *Unum Life Ins. Co. v. Ward,* 526 U.S. 358, 377-380 (1999). The Trust is not bound by the actions of Ms. Asheroff, since only the Trustees are authorized to adopt and/or amend the Pension Plan.

11. The Trustees did not amend the Plan to provide for five-year vesting for participants covered by a collective bargaining agreement (such as Banuelos) until 1998. This revision was effective for only those employees working after January 1, 1998.

12. Banuelos did not work in covered employment after January 1, 1998 Consequently, Banuelos is not entitled to the benefits of five-year vesting provided by Amendment No. 98-1-P.

13. The equitable doctrine of reformation of a written instrument due to scrivener's error is available in an ERISA action to reform a pension plan. *International Union v. Murata Erie North American, Inc.*, 980 F.2d 889, 907 (3d Cir. 1992); *See also Cinelli*, 61 F.3d at 1445.

14. Under the doctrine of scrivener's error, a mistake made in drafting a document may be reformed based upon parol evidence, provided the evidence is clear, precise, convincing, and of the most satisfactory character that a mistake has occurred and that the mistake does not reflect the intent of the parties. *Id.* The inclusion of § 4.07 (e) in the 1994 compilation is the result of a scrivener's error.

15. To the extent that co-counsel's 1994 compilation constitutes a version of the Plan which might be binding on the CLPT, the 1994 compilation is ambiguous with respect to the number of years required to earn a vested pension. The Trustees never intended to amend the Plan to provide for five-year vesting in 1993. Moreover, allowing Banuelos to take advantage of the mistakes made with respect to the handling of Amendment No. 93-1-P would result in a windfall to Banuelos, and a potential benefit improvement to other participants never intended or contemplated by the Trustees or the settlors of the Trust. Accordingly, the 1994 Compilation should be, and hereby is, reformed to delete § 4.07 (e). *Murata*, 980 F.2d at 907-08.

16. Remand to the plan administrator is appropriate where that administrator has "construe[d] a plan provision erroneously" and therefore has "not yet had the opportunity of applying the [p]lan, properly construed, to [a claimant's] application for benefits." *Canseco v. Construction Laborers Pension Trust for Southern California,* 93 F.3d 600, 609 (9th Cir. 2000). However, where the plan administrator "applied the right standard, but came to the wrong conclusion," remand is unnecessary. *Grosz-Salomon v. Paul Revere Life Ins. Co.,* 237 F.3d 1154, 1163 (9th Cir. 2000).

17. Here, Plaintiff's appeal was premised on the erroneous inclusion of § 4.07(e). The plan administrator also relied on the same erroneous version of the 1994 plan document in denying Banuelos' appeal for benefits.

Therefore, it is hereby ordered that Plaintiff's suit be REMANDED to the plan administrator for a determination as to Plaintiff's eligibility for benefits under the correct version of the Plan. The court retains jurisdiction over any future claims arising from this case.

Dated: November 7, 2002

/s/ Robert J. Kelleher
Robert J. Kelleher
United States District Judge

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

EIJINIO BANUELOS, Plaintiff, v. CONSTRUCTION LABORERS TRUST FUNDS, Defendant.	Case No. CV 00-05630 RJK **AMENDED ORDER DENYING CROSS-MOTIONS FOR SUMMARY JUDGMENT** (Filed Sep. 24, 2001)

The Court heard Plaintiff Eijinio Banuelos and Defendant Construction Laborers Trust Funds' (the "Trust") cross-motions for summary judgment on July 23, 2001. After considering the papers submitted by the parties, the case file and argument of counsel, the Court DENIES the motions.

I. BACKGROUND

A. The Parties

The Trust is an express trust established effective June 15, 1962 pursuant to a written Trust Agreement and Declaration of Trust executed on October 16, 1962. Pursuant to the terms of various collective bargaining agreements between the Southern California District Council of Laborers (the "District Council") and certain employers' associations, the Trust created and maintained a pension plan. The plan is a multiemployer defined benefit pension plan within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Board of Trustees is the governing body of the Trust. Half of the members of the Board are appointed by the District

Council and half are appointed by the employers' associations.

Plaintiff is a retired construction laborer. He worked as a construction laborer within the area covered by the Trust for 25 years from 1966 to 1991. Throughout his employment, Plaintiff was a member of Laborers Local 585, a local union affiliated with the District Council. Plaintiff's right to a pension is governed by the provisions of the pension plan.

Plaintiff retired from construction work in 1992 at the age of 62. On January 23, 1995, Plaintiff turned 65 years old. Plaintiff is currently 71 years old.

B. The Pension Plan

At the time Plaintiff retired, the pension plan provided for three different forms of regular pension: Plan One for those who have completed at least 10 years of credited service; Plan Two for those who have completed at least 15 years of credited service; and Plan Three for those who have completed at least 25 years of credited [sic]. The plan sets forth applicable "break in service" rules for each form of regular pension and specifies how credits are to be calculated. Generally, a participant is credited with one year of service for each year in which he was employed more than 1000 hours. A "break in service" occurs in each calendar year during which the participant completed less than 501 hours worth of service. Because the undisputed facts show that Plaintiff's years of credited service total no more than seven years under any applicable "break in service" rules, this dispute concerns Plaintiff's entitlement to pension benefits under Plan One.

At the time Plaintiff retired, a minimum of 10 credited years were required for a vested pension. In September 1998, Plaintiff's attorney Richard A. Weinstock received from the Trust a copy of the then applicable pension plan in a separate lawsuit involving a different plan participant. The cover page of this plan states it is the version "[a]s amended to June 30, 1994" (the "1994 Plan"). (Plaintiff's Ex. 3.)

According to the notes in the 1994 Plan, two sections in the vesting provisions of Article IV were added by amendment in 1990 and 1993, reducing the years of services required for vesting from ten to five years. Amendment No. 90-2-P added Section 4.07(d), which provides five year vesting for all participants *not* covered by a collective bargaining agreement. (*Id.* at 44.) Amendment No. 93-1-P (the "1993 Amendment") added Section 4.07(e), which provides five year vesting for all other participants, *i.e.*, participants covered by a collective bargaining agreement. Specifically, Section 4.07(e) states:

> an employee who (i) has accumulated *five* years of Credited Serviced [sic] computed as provided in Section 4.04A and 4.06, (ii) is 65 years or older, and (iii) has not had a break in service during the period referenced in (i) above shall have a vested pension.

(*Id.* (emphasis added).)[1] According to the footnote in the 1994 Plan – the version upon which Plaintiff relies – the 1993 Amendment was adopted on April 13, 1993, and was by its terms made retroactive to January 1, 1988. (*See id.*

[1] The notes in the 1994 Plan indicate other changes to the pension plan were made pursuant to the 1993 Amendment.

at 43 n.* ("Amendment No. 93-1-P, adopted 4/13/93, effective 1/1/88"). Because Plaintiff did not retire until 1992, Section 4.07(e), if valid, appears to apply to Plaintiff.[2] This amendment lies at the heart of the pending dispute.

In December 1998, the Trust again amended the pension plan's vesting provisions. The new Section 4.07(g) added by the 1998 Amendment also addresses five year vesting for participants covered by a collective bargaining agreement and contains terms slightly different from the terms set forth in Section 4.07(e) of the 1994 Plan. The parties did not submit a copy of the pension plan as it existed in 1998; and it appears that Plaintiff was not aware of this newly amended plan when he applied for pension benefits in 1999.

In sum, three versions of the pension plan are at issue: the pre-1993 Amendment version; the version reflecting changes made by the 1993 Amendment; and the version reflecting changes made by the 1998 Amendment.

C. Plaintiff's Pension Application

In August 1999, presumably in reliance on the terms of the 1994 Plan, Plaintiff, through his attorney, submitted an application for a normal retirement pension. On November 29, 1999, the plan administrator advised Plaintiff that his application was conditionally approved pending his completion of 501 or more hours of work in covered

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[2] The Trust, citing internal records, disputes the effective date of the 1993 Amendment set forth in Plaintiff's Ex. 3, notwithstanding the language expressly stated in the plan document. (*See* Def.'s Motion for Modification at 2-3.)

employment. (*See* Def's Exhibits in Support of Motion for Summary Judgment ("Def.'s Ex."), Ex. 22.) The plan administrator issued the conditional approval based on its calculation that Plaintiff had earned six years of vesting credit under Plan One (in the years 1972, 1973, 1976, 1977, 1978 and 1988). (*See* Def.'s Exs. 21 & 22.) However, because of several one-year breaks in service beginning in 1990, the plan administrator would not recognize any of the pre-1990 credit years unless Plaintiff complied with the credit year reinstatement provisions.[3]

Plaintiff appealed the November 29, 1999 decision by a letter dated December 27, 1999. (*See* Def.'s Ex. 23.) Plaintiff appealed both the plan administrator's method of computing his credit hours and the amount of conditional benefits. Plaintiff's appeal letter cited the five year vesting language set forth in Section 4.07(e) of the 1994 Plan. On January 25, 2000, the plan administrator notified Plaintiff that the Pension Appeals Committee denied his appeal.

On May 24, 2000, Plaintiff commenced this action, alleging three claims for relief. Two of the claims seek declaratory relief and damages under ERISA. Plaintiff alleges that his pension benefits vested with five years of service as of January 1, 1989, pursuant to the terms of the 1994 Plan. Plaintiff also alleges that the 1994 Plan does

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[3] The parties disagree about the number of hours Plaintiff must work to obtain credit for pre-1990 years of service. The Trust contends it is 501 hours. Plaintiff contends that either (1) Plaintiff is not required to work any additional hours because he did not have any "break in service" as defined by the 1994 Plan or (2) the Trust can require no more than 1 more hour of covered employment. The plan administrator's November 1999 notice fails to identify the section of the pension plan upon which the administrator relied for the 501 additional hours requirement.

not require him to work an additional 501 hours to "rehabilitate" his pre-1990 hours of service. Further, Plaintiff alleges that the plan administrator's interpretation of the plan requiring an additional 501 hours of construction work is tantamount to a denial of benefits because of Plaintiff's advanced age.[4] Hence, the parties refer to the conditional grant of benefits as a "denial" of benefits for purposes of this lawsuit.[5]

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[4] Defendant argues that the Complaint does not contain allegations that challenge the validity of the additional 501 hours requirement imposed on Plaintiff. Defendant's argument has no merit.

It is true that the Complaint does not contain a sentence explicitly alleging that the 501 additional hours of work requirement is invalid. However, the federal pleading rules do not require such precision in pleading. The "main purpose of the complaint is to provide notice to the defendant." *Self Directed Placement Corp. v. Control Data Corp.*, 908 F.2d 462, 466 (9th Cir. 1990). "The rules clearly 'reject the approach that pleading is a game of skill in which one misstep by counsel may be decisive to the outcome and accept the principle that the propose [sic] of pleading is to facilitate a proper decision on the merits." *Id.* A complaint need only allege "enough details as to provide defendant and the court with a fair idea of the basis of the complaint and the legal grounds claimed for recovery." *Id.*

Here, the allegations in the Complaint sufficiently show that Plaintiff seeks a declaration that the Trust's conditional approval of Plaintiff's pension application, which imposes the additional 501-hour requirement, is unlawful under ERISA. (*See* Complaint, ¶ 12 (describing the conditional approval requiring Plaintiff to complete "an additional 501 hours of employment" as "tantamount to a denial" of benefits); ¶ 15 (alleging that Plaintiff is not "subject to "break in service" rules); ¶ 16 (alleging that "Defendant claims that it has interpreted the Plan correctly in that its 'break in service' rules require plaintiff to work an additional 501 hours"); ¶¶ 19-20 (alleging that the Trust has failed to pay plaintiff benefits as required by law).

[5] Plaintiff's third claim for relief alleges a violation of the Age Discrimination in Employment Act. In November 2000, Plaintiff stipulated to the dismissal of this age discrimination claim.

D. Discovery of the Alleged Mistake

According to the Trust, in March 2001, while reviewing documents during discovery, the Trust's attorney, Charles Noneman, discovered the 1994 Plan upon which Plaintiff relies is an *incorrect* version of the pension plan in effect in 1994. Defense counsel discovered two versions of the 1993 Amendment in the Trust's records. He also discovered various typed versions of the pension plan reflected the inclusion of portions of both versions of the 1993 Amendment. He concluded that the version of the 1993 Amendment actually adopted by the Board of Trustees in April 1993 did *not* add Section 4.07(e) (the five year vesting provision) to the pension plan. On March 21, 2001, defense counsel sent a letter to Plaintiff's counsel advising him of the newly discovered error. (*See* 7/9/01 Noneman Decl., Ex. 26.)

On June 4, 2001, the Trust filed its motion for summary judgment or, in the alternative, motion for summary adjudication of issues. On June 29, Plaintiff filed an opposition. On July 16, the Trust filed a reply.

On June 22, 2001, Plaintiff filed a cross-motion for summary judgment. On July 9, the Trust filed its opposition. On July 16, Plaintiff filed a reply.

On July 26, 2001, the Court issued its original order denying the cross-motions for summary judgment. On August 6, 2001, Defendant filed a motion to correct and/or modify the Court's order pursuant to Federal Rule of Civil Procedure 60. Defendant argued that the July 26 order contains both clerical and substantive errors. Plaintiff filed his opposition to this motion on August 30, 2001 and Defendant filed its reply on September 10, 2001. A few of the arguments raised in Defendant's motion for modification has

merit. The Court hereby issues this amended order denying the cross-motions for summary judgment. The amended portions address the issues raised in Defendant's motion for modification.

II. DISCUSSION

A. Summary Judgment Standard

Summary judgment is proper if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). A fact is material only if it is relevant to a claim or defense and its existence might affect the suit's outcome. *See T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Assoc.*, 809 F.2d. 626, 630 (9th Cir. 1987). A court may not, on a motion for summary judgment, evaluate the credibility of the evidence submitted by the parties. *See Leslie v. Grupo ICA*, 198 F.3d 1152, 1157-59 (9th Cir. 1999).

The moving party bears the burden of demonstrating the absence of a genuine issue of material fact for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986). "[T]he burden on the moving party may be discharged by 'showing' – that is, pointing out to the district court – that there is an absence of evidence to support the nonmoving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986); *see Musick v. Burke*, 913 F.2d 1390, 1394 (9th Cir. 1990). To demonstrate that the non-moving party lacks sufficient evidence to entitle it to judgment, the moving party must affirmatively show the absence of such evidence in the record, either by deposition testimony, the

inadequacy of documentary evidence or by any other form of admissible evidence. *See Celotex*, 477 U.S. at 322. The moving party has no burden to negate or disprove matters on which the opponent will have the burden of proof at trial. *See id.* at 325.

A non-moving party's allegation that factual disputes persist between the parties will not automatically defeat an otherwise properly supported motion for summary judgment. *See* Fed. R. Civ. P. 56(e) (non-moving party "may not rest upon the mere allegations or denials of the adverse party's pleadings, but . . . must set forth specific facts showing that there is a genuine issue for trial."). "[A] mere 'scintilla' of evidence will be insufficient to defeat a properly supported motion for summary judgment; instead, the nonmoving party must introduce some 'significant probative evidence tending to support the complaint." *Fazio v. City and County of San Francisco*, 125 F.3d 1328, 1331 (9th Cir. 1997), *quoting Anderson*, 477 U.S. at 249, 252. In judging evidence at the summary judgment stage, courts must draw all reasonable inferences in favor of the party against whom summary judgment is sought. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Chaffin v. United States*, 176 F.3d 1208, 1213 (9th Cir. 1999).

B. The Trust's Mistake Claim

The Trust submits various forms of evidence to support its contention that the Trustees did not adopt five year vesting for participants like Plaintiff as part of its 1993 Amendment. The Trust argues that the undisputed facts show that Plaintiff never qualified for a vested benefit under any applicable version of the pension plan.

Before the Court addresses the merits of the Trust's mistake claim, the Court must determine whether it should allow the introduction of parol evidence to support the mistake claim. The Court considers both the equitable mistake doctrine and the general rule forbidding the examination of evidence outside the administrative record.

1. Equitable Mistake Doctrine

The Trust requests that the Court disregard the written language of the 1994 Plan and consider parole [sic] evidence showing Section 4.07(e) was erroneously included in the typed 1994 Plan. In essence, the Trust is seeking equitable reformation of the written plan document. Unfortunately, the only authority it cites in support of this issue is inapposite. (*See* Motion at 22 (citing *Snyder v. Elliot W. Dann Co., Inc.*, 854 F. Supp. 264, 272 (S.D.N.Y. 1994) (holding alleged oral modifications are not actionable under ERISA and unambiguous disclaimer in summary plan document that the terms of the plan shall govern in the case of conflict precludes any separate contract claim based solely on the language – a typographical error – of the summary plan description). Indeed, neither party addresses relevant circuit cases that apply the equitable mistake doctrine in the ERISA context. *See Int'l Union v. Murata Erie North Am., Inc.*, 980 F.2d 889, 907-08 (3d Cir 1992) ("*Murata*") (permitting the examination of parol evidence to determine whether a provision allowing "reversion to the company of excess funds due to erroneous actuarial computation" was excluded from plan documents as the result of a "scrivener's error" rather than intentional exclusion); *Cinelli v. Security Pacific Corp.*, 61 F.3d 1437, 1444-45 (9th Cir. 1995)

(discussing *Murata* and the limited circumstances where the doctrine may apply).

Murata and *Cinelli* instruct the Court to evaluate whether application of the equitable mistake doctrine in this particular case would be inconsistent with ERISA's strong preference for ensuring that an employee's rights and obligations can be readily ascertained from the written terms of the plan documents. *Murata*, 980 F.2d at 907-08; *Cinelli*, 61 F.3d at 1444-45. Where the plan documents contain some ambiguity and the result would be a windfall to either party, reformation for a "scrivener's error is permissible. *See Murata*, 980 F.2d at 907-08; *see also Cinelli*, 61 F.3d at 1445 (discussing *Murata*). However, where the terms of the formal plan documents are unambiguous and clear as to benefits, allowing either the employee or employer to attack those express terms would be inconsistent with the goals and polices [sic] of ERISA. *See Cinelli*, 61 F.3d at 1445 (distinguishing *Murata* on its facts and declining to apply the mistake doctrine to allow consideration of parol evidence as to whether the unambiguous supplemental insurance plan mistakenly omitted vesting language).

Application of the equitable mistake doctrine is appropriate in this particular case. First, the 1994 Plan contains ambiguous provisions concerning participants' entitlement to pension benefits. For example, Article II of the 1994 Plan clearly provides that there are only three plans for regular pensions: Plan One for those who have completed at least 10 years credited service; Plan Two for those who have completed at least 15 years of credited service; and Plan Three for those who have completed at least 25 years of credited service. (Complaint, Ex. A, at 7-8). Plan One is the only plan at issue here. Therefore, the

1994 Plan states that *ten years of credited service* is the minimum requirement for regular pension benefits. However, Article IV then proceeds to provide two *five year* vesting provisions (one of which is not a mistake). The conflict between the five years requirement for vesting and the ten years requirement for benefits in Article II makes the plan ambiguous.[6]

Second, similar to *Murata*, the alleged error in this case can be considered a windfall to Plaintiff. At the time he retired in 1992 (at age 62), the minimum number of credited years required for a vested pension for employees in his position was 10 years. The 1993 Amendment was adopted *after* Plaintiff retired. The only reason it may apply to Plaintiff is because its terms, as stated in the 1994 Plan, made it retroactive to January 1988. (*See* section II. B., *supra*, at 3.) Thus, this is not a case where the plaintiff could be said to have reasonably relied on the written pension plan documents when he retired. Under the circumstances, applying the mistake doctrine would not conflict with ERISA's goal of providing clear plan documents.

2. Whether The Court's Review Is Limited to the Administrative Record

The parties agree that the plan documents grant the Board of Trustees (or the plan administrator) with discretionary authority to interpret the terms of the plan and

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[6] The Trust has since modified the language in Article II. Plan One now requires the participant to have "accumulated years of Credited Service . . . as determined in accordance with Article IV in each year of which he was employed not less than 1000 hours. . . . " (Def's Ex. 13 at 8.)

Plaintiff's eligibility for benefits. Therefore, the parties agree that the applicable standard of review of the plan administrator's decision is for abuse of discretion, *i.e.*, whether the decision was arbitrary and capricious. *See McKenzie v. General Tel. Co. of Cal.*, 41 F.3d 1310, 1314 (9th Cir. 1994) (where the plain language of the plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, the abuse of discretion or "arbitrary and capricious" standard applies).

When the abuse of discretion standard is applicable, the district court's review is generally limited to the administrative record. *See, e.g., id*, at 1316; *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993). The Ninth Circuit has reasoned that "[p]ermitting a district court to examine evidence outside the administrative record would open the door to the anomalous conclusion that a plan administrator abused its discretion by failing to consider evidence not before it." *Taft*, 9 F.3d at 1472. Moreover, allowing such an expanded review would permit federal district courts to function as substitute plan administrators and impede an important purpose of the ERISA statute: to provide prompt resolution of benefits claims by plan administrators. *Id.* However, evidence outside the administrative record may be considered in limited circumstances. *See, e.g., Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976-77 (9th Cir. 1999) ("evidence [outside the administrative record] may be considered to determine if a plan administrator's decision was affected by its conflict of interest"); *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F.3d 938, 944 (9th Cir. 1995) (where the appropriate standard of review of the administrative decision is *de novo* review, a district court

may consider new evidence when necessary to conduct an adequate review of the benefit decision).

In this case, Plaintiff refers to this "no new evidence" rule and urges the Court to disregard all of the Trust's evidence concerning the alleged mistake, namely all evidence showing the five year vesting provision (Section 4.07(e)) was never duly adopted as part of the 1993 Amendment and erroneously included in the 1994 Plan. It is undisputed that the Trust's mistake claim and evidence in support thereof are not part of the administrative record.

This case presents an unusual circumstance. Generally, the this [sic] "no new evidence" rule comes into play during a post-administrative appeal lawsuit when the parties seek to submit additional evidence concerning a claimant's entitlement to benefits (*e.g.*, testimony or report by a doctor or vocational expert on the extent of the claimant's disability). *See, e.g., McKenzie*, 41 F.3d at 1316 (holding the district court erred by considering vocational evidence outside the administrative record); *Taft*, 9 F.3d at 1471-72 (holding the district court erred by considering a doctor's testimony concerning the plaintiff's disability that was not in the administrative record). In those instances, it is logical to limit review of the administrator's decision to the record upon which the decision was based in assessing whether the decision constitutes an abuse of discretion.

Here, neither party is requesting that the Court consider new records of the historical facts that underlie Plaintiff's benefits claim. Rather, the new evidence concerns the validity of the version of the pension plan upon which Plaintiff's benefits application was based. That version of the pension plan did not even exist at the time

Plaintiff retired; Plaintiff's attorney discovered the 1994 Plan (and Section 4.07(e)'s five year vesting provision) in 1998 while litigating an unrelated lawsuit against the Trust. The validity of the 1994 Plan was never in doubt until the Trust's lawyers discovered discrepancies in the Trust's historical records during this post-administrative appeal lawsuit.

No published decision addresses the issue before the Court. After considering the purpose of the "no new evidence" rule in the ERISA context and the facts of this case, the Court concludes that the rule does not preclude the consideration of the Trust's evidence of mistake. Considering evidence outside the administrative record in this limited circumstance will not lead to the "anomalous" result discussed in *Taft*. Nor will the Court be substituting its judgment for that of the plan administrator. The issue before the Court is a threshold issue which must he decided *before* the Court reviews the plan administrator's decision for abuse of discretion. If the Court ultimately determines that Plaintiff cannot rely on Section 4.07(e) of the 1994 Plan because it was never adopted by the Trust, the Court may remand this case for further proceedings before the Trust's plan administrator. *Cf. Canseco v. Construction Laborers Pension Trust*, 93 F.3d 600, 609 (9th Cir. 1996) ("Remand to the plan administrator is appropriate where that administrator has 'construe[d] a plan provision erroneously' and therefore has 'not yet had the opportunity of applying the [p]lan, properly construed, to [a claimant's] application for benefits" unless reevaluation of the merits of the retiree's claim is unnecessary). Therefore, the Court will consider evidence relating to the Trust's mistake claim.

3. Triable Issues of Fact As To Mistake

Under the doctrine of mistake or scrivener's error, the mistake in drafting a document may be reformed based on parol evidence, "provided the evidence is '*clear, precise, convincing and of the most satisfactory character*' that a mistake has occurred and that the mistake does not reflect the intent of the parties." *Murata*, 980 F.2d at 907 (emphasis added). Thus, the party seeking to establish such an error must meet a "rigorous test . . . given the clear and convincing standard of proof." *Id.* at 908.

The Trust raises various arguments and submits various types of evidence in support of its mistake defense. The Court need not address all the arguments because certain key documents and declarations show that triable issues of fact exist.

According to the Trust's witness declarations, the actual events surrounding the 1993 Amendment are as follows:[7] In

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[7] Most of the following facts are set forth in the Declaration of John S. Miller, the Trust's long time attorney and a member of the firm representing the Trust in this lawsuit. Plaintiff moves to strike Mr. Miller's testimony on two grounds. First, Plaintiff complains that Mr. Miller was never identified as a witness in this case until long after the February 28, 2001 discovery cut-off date. Therefore, Plaintiff requests that the Court strike the testimony pursuant to Local Rule 27 (sanction for failure to conform to the Local Rules) or Fed. R. Civ. P. 37(c) (exclusion of evidence not disclosed as required by Rule 26(a) unless such failure is harmless). Second, Plaintiff argues that the declaration is inadmissible because it lacks foundation. Mr. Miller is neither one of the Board members nor the actual author of disputed Section 4.07(e).

The Court denies Plaintiff's motion to strike. The record shows the Trust did not discover the alleged mistake until March 2001, after the discovery cut-off. The failure to identify Mr. Miller as a witness earlier is harmless because summary judgment will not be granted on the basis of Mr. Miller's testimony and the Court may reopen discovery for the limited purpose of allowing the deposition of Mr. Miller. Moreover,

(Continued on following page)

1993, the Trustees adopted the 1993 Amendment in response to a law that amended ERISA's definition of "normal retirement age." Co-counsel for the Trust prepared proposed amendments to the pension plan to comply with the change in the law. The first draft of the 1993 Amendment transmitted to the Board of Trustees is a two page document. (*See* Def's Ex. 14.) The first page proposes two new sections, one amending language of Article I of the pension plan and the other amending language of Article II of the plan. The second page contains the five year vesting provision – *i.e.*, the proposed Section 4.07(e) for Article IV of the plan. The board minutes show this version was read at the meeting held on February 23, 1993 (first reading). (*See* Def.'s Ex. 15.) After the first reading of the 1993 Amendment, the amendment was revised and transmitted to the Board of Trustees for a second reading, because amendment may not be adopted until the second reading. The version of the 1993 amendment *actually read and adopted* after the second reading, which occurred on April 13, 1993, *deleted* the provision adding Section 4.07(e) to the pension plan. This correct version of the amendment is a one page document. (*See* Def.'s Ex. 16.)

Mr. Miller's declaration does not lack proper foundation. The declaration and other records show he was present at all relevant board meetings and familiar with the process leading to the adoption of the 1993 Amendment.

Plaintiff also objects to the Trust's documentary evidence on the ground that the documents were not given to Plaintiff until long after the discovery cut off date. This failure to comply with the discovery cut-off is harmless for the same reason allowing Mr. Miller to testify is harmless. If necessary, the Court will reopen discovery for the limited purpose of permitting Plaintiff to conduct discovery on the mistake issue.

However, the Trust's own records *contradict* its witness' version of the historical facts. First, the Trust's own Exhibit 9 is a copy of the 1993 Amendment that contains proposed Section 4.07(e). The bottom of the second page shows someone filled in the dates for the "First Reading" and "Second Reading." Thus, this document shows the version containing disputed Section 4.07(e) *went through the second reading on April 13, 1993*. (*See* Def.'s Ex. 9.) Second, the minutes for the April 13, 1993 board meeting expressly state that the version of the 1993 Amendment that was approved at the second reading *contained Section 4.07(e)*. (*See* Def's Ex. 17.) Finally, the minutes for the June 8, 1993 board meeting shows the Board of Trustees "approve[d] the minutes [of the April 13, 1993] meeting as presented." (6/29/01 Weinstock Decl., Ex. D.)

In response, the Trust submits the declaration of Robert Gaza, the person who either prepared or supervised the preparation of the board minutes at issue, to show that the board minutes are inaccurate. (*See* Gaza Decl., ¶ 3.) Mr. Gaza states that he was present at the meeting but he did not catch the error in the minutes when it was approved. (*Id.*) The Trust also submits the declarations of two persons who attended the relevant board meetings – Mr. Miller, the Trust's attorney, and John Smith, one of the Trustees, who state the minutes do not accurately reflect the Board of Trustees' decision on April 13, 1993. (*See* Miller Decl., ¶ 14; Smith Decl. ¶ 4.)

In sum, resolution of the mistake defense depends heavily on the credibility of the Trust's witnesses. In order to resolve this question, a trier of fact must evaluate whether these witnesses' testimony concerning what was adopted at a board meeting seven years ago and determine whether such testimony is strong enough to overcome the

prima facie case that the Trust's own organizational records support. On a summary judgment motion, the Court cannot determine credibility. Drawing all reasonable inferences in favor of Plaintiff, the Court must conclude that the record in this case creates a genuine issue of material fact.

III. DISPOSITION

Because there is a triable issue of material fact, the Court DENIES the parties' cross-motions for summary judgment of the ERISA claims.

IT IS SO ORDERED.

DATED: September, 24, 2001.

/s/ Robert J. Kelleher
ROBERT J. KELLEHER
United States District Judge

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

EIJINIO BANUELOS, Plaintiff-Appellant, v. CONSTRUCTION LABORERS TRUST FUNDS FOR SOUTHERN CALIFORNIA, Defendant-Appellee.	No. 02-57096 D.C. No. CV-00-05630-RJK Central District of California, Los Angeles ORDER (Filed Dec. 8, 2004)

Before: B. FLETCHER, H. PREGERSON, BRUNETTI, Circuit Judges.

The panel has voted to deny the petition for rehearing. Judge Pregerson has voted to deny the petition for rehearing en banc and Judges B. Fletcher and Brunetti so recommend.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for panel rehearing and the petition for rehearing en banc are denied.

29 C.F.R. PART 2560 – RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

Sec. 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if –

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review

procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102-3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees) –

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference –

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if,

in addition to complying with the requirements of paragraph (b) of this section –

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that –

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination. (1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant,

in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90- day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than

48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of –

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments –

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan,

provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit

determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan

expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2)

of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant –

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations. (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair

review of a claim and adverse benefit determination unless the claims procedures –

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures –

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which –

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) Timing of notification of benefit determination on review. (1) In general. (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) Post-service claims. (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In

the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits –

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances,

or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(k) Preemption of State law. (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have

exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A "claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a "claim involving urgent care" within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a "claim involving urgent care" within the meaning of paragraph

(m)(1)(i) of this section shall be treated as a "claim involving urgent care" for purposes of this section.

(2) The term "pre-service claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term "post-service claim" means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term "notice" or "notification" means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term "group health plan" means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides "medical care" within the meaning of section 733(a) of the Act.

(7) The term "health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Applicability dates. (1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.